

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06314

Reg. Dist. No.

6373

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Allegany b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital, D. O. A.			d. STREET ADDRESS 801 Hilltop Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Frank J. Beachley			4. DATE OF DEATH Month June Day 28 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-88	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Steam Railroad		11. BIRTHPLACE (State or foreign country) Somerset Co. Pa.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Ira Beachley		
14. MOTHER'S MAIDEN NAME Rebecca Queer			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO.			17. INFORMANT 801 Hill Top Drive Mrs. Annie Beachley Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Liver, Crushed Chest DUE TO (b) Automobile Accident Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 30 Min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident			
20c. TIME OF INJURY Month, Day, Year Hour 9:20 p.m. 6/28/58		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Near Cumberland, Alleg. Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B. Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 28, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORY Beachdale	
22d. LOCATION (City, town, or county) R.D.1 Garrett, Somerset, Pa.		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Johnson		ADDRESS Berlin, Pa.		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
24b. REGISTRAR'S SIGNATURE Al. Leach					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1950

ALBANY

ALBANY, N. Y., JAN. 10, 1950

807 HILL STREET

ALBANY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove extra papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6374

CERTIFICATE OF DEATH

Reg. Dist. No.

06315

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle H. Last BENDER		4. DATE OF DEATH Month JUNE Day 25 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		10b. KIND OF BUSINESS OR INDUSTRY Pinzal Restaurant	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Hardy		14. MOTHER'S MAIDEN NAME Mary Stutzman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 165-22-4785	
17. INFORMANT Bruce J. Bender, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1958 to 6/25 , 19 58 , that I last saw the deceased alive on 6/25 , 19 58 , and that death occurred at 5:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 6/27/58 ACTUAL SIGNATURE Martin Rothstein, M.D. M.D. 48 Broadway PHYSICIAN'S NAME (Type) Martin Rothstein, M. D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-28-58	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JUN 30 '58	
24b. REGISTRAR'S SIGNATURE W. J. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66316

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREEN SPRING 85X-3	
c. LENGTH OF STAY IN 1b 26 DAYS		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle R. Last BIDENGER		4. DATE OF DEATH Month JUNE Day 28 Year 19 58.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 15,
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mip.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) FORT ASHBY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE BIDENGER		14. MOTHER'S MAIDEN NAME REBECCA CRAWFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia. 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) Arteriosclerosis Anemia - secondary 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 58 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 6-2-58 , 19 58 , to 6-28-58 , 19 58 , that I last saw the deceased alive on 6-28-58 , 19 58 , and that death occurred on 6-28-58 , 19 58 , at 10:00 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 125 1/2 Center St, Cumberland, Md DATE SIGNED 6-30-58 ACTUAL SIGNATURE Howard L. Tolson PHYSICIAN'S NAME (Type) DR. HOWARD L. TOLSON 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 1 22c. NAME OF CEMETERY OR CREMATORY Springfield Hill 22d. LOCATION (City, town, or county) (State) Springfield W. Va 23. FUNERAL DIRECTOR'S SIGNATURE Keith S. Stapp ADDRESS Remney W. Va 24a. REC'D BY REGISTRAR DATE JUL 7 1958 24b. REGISTRAR'S SIGNATURE W. H. Edwards			

CERTIFICATE OF DEATH

NAME: [illegible] SEX: [illegible] AGE: [illegible]
DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]

Chronic degenerative disease

arteriosclerosis - coronary

6-5-28

6-5-28

Dr. J. H. [illegible] M.D.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6375 CERTIFICATE OF DEATH

06317

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westernport</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St.</u>				STREET ADDRESS <u>Main St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Rose L. Broderick</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 5 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 12. 1879</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George M. McWilliams</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Whitehair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic</u>						<u>5 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Pulmonary Edema</u>		<u>1 Day</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 4, 1958</u> to <u>June 5, 1958</u>, that I last saw the deceased alive on <u>June 4, 1958</u>, and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul R. Wilson</u>				DATE SIGNED <u>Ashfield St. Piedmont, W. Va. 6-5-58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/9/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westernport, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Piedmont, W. Va.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6321

CERTIFICATE OF DEATH

06318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 31 Mullin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen Burke				4. DATE OF DEATH Month June Day 28 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Handel				14. MOTHER'S MAIDEN NAME Christine Barnhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. one		17. INFORMANT Mrs. Dwight Proudfoot Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) Arteriosclerotic C.V. Disease						INTERVAL BETWEEN ONSET AND DEATH 6 wks 5 yrs 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 27, 1958 to June 28, 1958 , that I last saw the deceased alive on June 27, 1958 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett				ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland, Md.			
PHYSICIAN'S NAME (Type) Clay E. Durrett				DATE SIGNED 7/1/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE JUL 3 '58		24b. REGISTRAR'S SIGNATURE W. E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of death: _____

5. Place of death: _____

6. Cause of death: _____

7. Signature of physician: _____

8. Signature of registrar: _____

9. Date of registration: _____

10. Place of registration: _____

6322

CERTIFICATE OF DEATH

Reg. Dist. No. 06319

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 38 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 East Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle B. Last Callis		4. DATE OF DEATH Month June Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Painting Contractor Hoyes, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Callis		14. MOTHER'S MAIDEN NAME Caroline Deahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-6729	
17. INFORMANT Mrs. Charles B. Callis, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Compensation of heart failure Hddi DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Art. C. V. S. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 1958 , that I last saw the deceased alive on June 4, 1958 , and that death occurred at 2:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Lusby M.D.		DATE SIGNED 6/25/58	
PHYSICIAN'S NAME (Type) Thomas F. Lusby 121 Bedford St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 28, 1958	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24b. REGISTRAR'S SIGNATURE James F. Scarpelli	
24a. REC'D BY REGISTRAR DATE JUN 27 '58		24b. REGISTRAR'S SIGNATURE James F. Scarpelli	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6323

CERTIFICATE OF DEATH

06320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 28 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLIAN P CARPENT		4. DATE OF DEATH Month JUNE Day 22 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1920
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady Shoes Dept. Store		11b. KIND OF BUSINESS OR INDUSTRY MARYLAND Cumberland	
11c. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA BUCY		14. MOTHER'S MAIDEN NAME PEARL REED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 0580797	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung c 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 mon			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1957 to 6/22 , 1958, that I last saw the deceased alive on 6/22 , 1958, and that death occurred at 9:00 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 6/22/58			
ACTUAL SIGNATURE George M. Simons M.D.		PHYSICIAN'S NAME (Type) DR GEORGE M. SIMONS	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-58	
22c. NAME OF CEMETERY OR CREMATORY RestLawnMemorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 24 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06321

Reg. Dist. No.

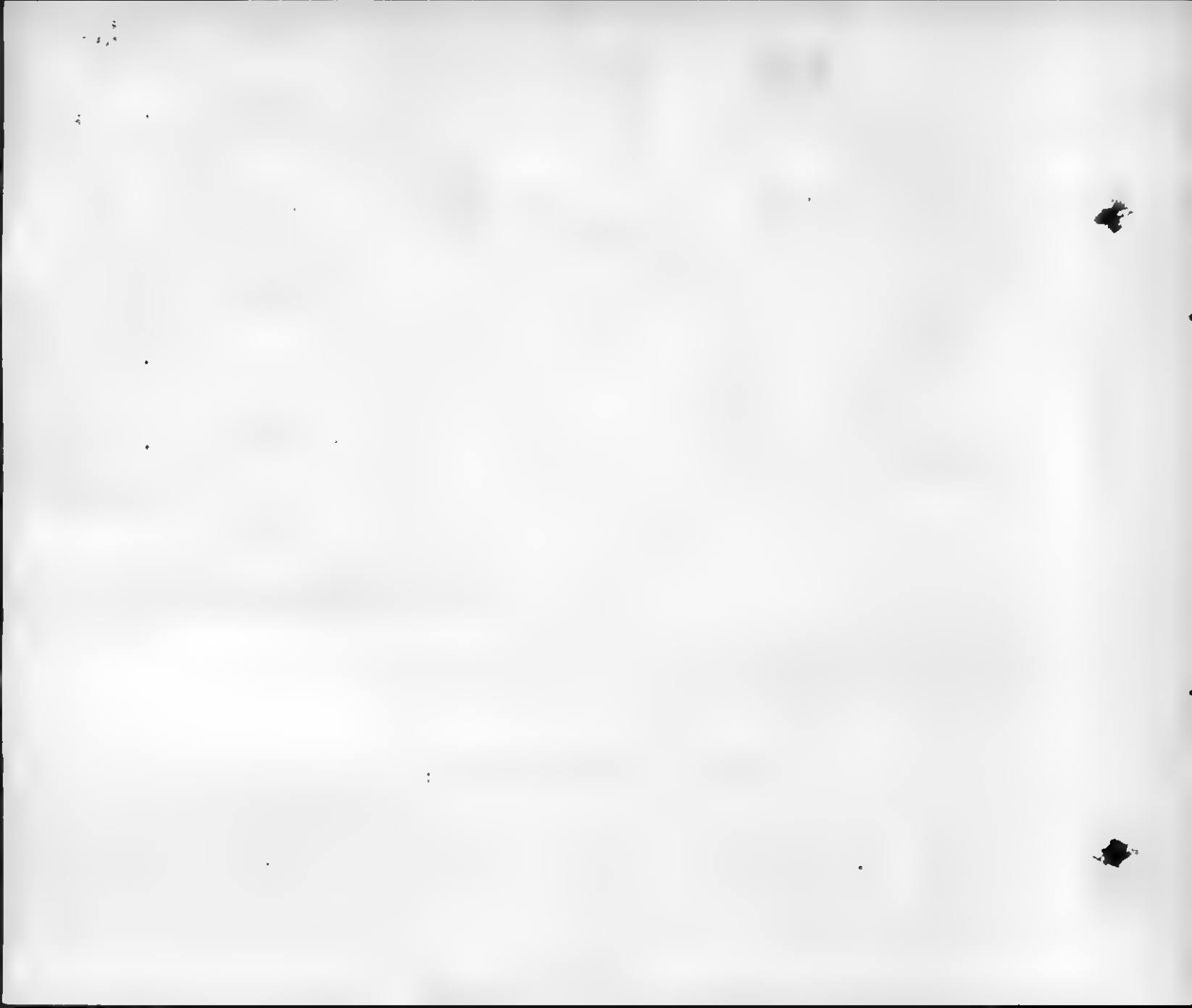
1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 435 PENNSYLVANIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY		Middle ELIZABETH		Last CLAY		4. DATE OF DEATH Month JUNE		Day 3		Year 1958		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH December 55, 1883		9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 7		11. IF UNDER 24 HRS Days 7		12. IF UNDER 24 HRS Hours 7		13. IF UNDER 24 HRS Min 7		14. IF UNDER 24 HRS Sec 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY Little Orleans U.S.A.		13. FATHER'S NAME Jonas POTTS		14. MOTHER'S MAIDEN NAME Mary Keefer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary congestion X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic carcinoma from DUE TO (c) carcinoma of left kidney		INTERVAL BETWEEN ONSET AND DEATH 1 day		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic passive congestion of liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) NONE		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Maryland		(State) Maryland		21. I certify that I attended the deceased from May 18, 1958 to June 3, 1958 that I lost saw the deceased alive on June 3, 1958 and that death occurred at 11:40 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hotel Albogon		DATE SIGNED June 3, 1958	
ACTUAL SIGNATURE Thomas F. Lewis		M.D. Hotel Albogon		PHYSICIAN'S NAME (Type) DR. THOMAS LEWIS		22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 6-7-58		22c. NAME OF CEMETERY OR CREMATORY St Patrick Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.		22e. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE W. F. Smith		24c. REGISTRAR'S SIGNATURE W. F. Smith		24d. REGISTRAR'S SIGNATURE W. F. Smith		24e. REGISTRAR'S SIGNATURE W. F. Smith		24f. REGISTRAR'S SIGNATURE W. F. Smith	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57



6392
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oldtown, Md.		c. LENGTH OF STAY IN 1b 21 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rd #1		e. STREET ADDRESS / Rd #1	
3. NAME OF DECEASED (Type or print) First Mary Middle Hott Last Crabtree		4. DATE OF DEATH Month June Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1906 May 26, 1906
9. AGE (in years last birthday) 52 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Shanks, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Hott		14. MOTHER'S MAIDEN NAME Florence Sirbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. None	17. INFORMANT Gilbert Crabtree, Oldtown, Md. Address Rt #1
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General malnutrition and pneumonia DUE TO to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, Cervix with metastasis. DUE TO to (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1, 1955 , to June 6, 1958 , that I last saw the deceased alive on June 19, 1958 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED CARLTON BRINSFIELD			
ACTUAL SIGNATURE CARLTON BRINSFIELD M.D.		DATE SIGNED Cumberland, Md.	
PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD		DATE SIGNED Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/9/58	22c. NAME OF CEMETERY OR CREMATORY Methodist Church Cem.	22d. LOCATION (City, town, or county) (State) Oldtown, Md. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Parks Funeral H. Berkeley Spgs, W. Va.		24a. REC'D BY REGISTRAR JUN 11 '58	24b. REGISTRAR'S SIGNATURE Red Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

06323

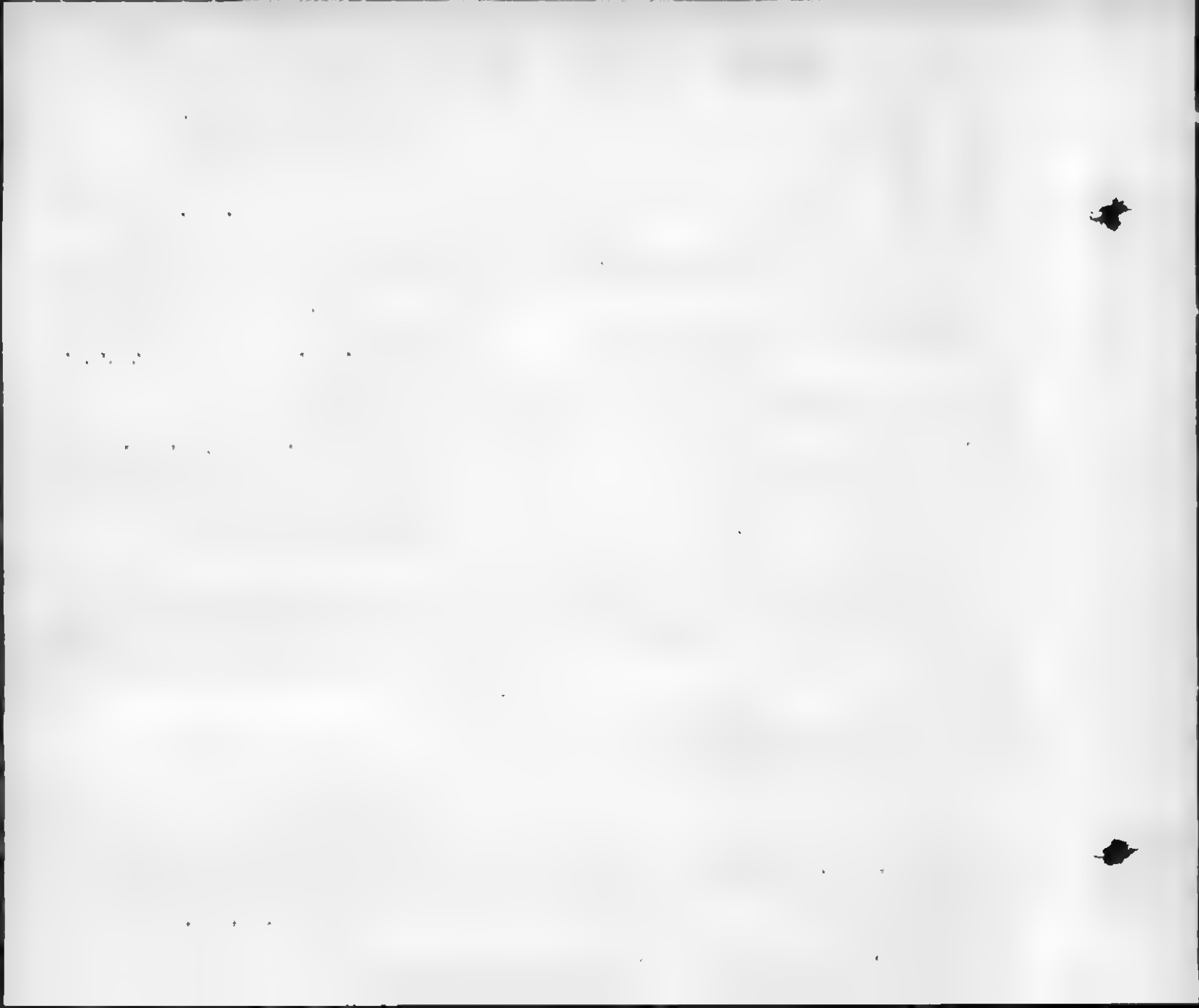
Reg. Dist. No.

6325

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>Olympia Hotel Balto. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Caudy</u> Last <u>Crawford</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/16/84</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>11</u> Min <u>11</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>10</u> Hours <u>11</u> Min <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wall Paper</u>		11. BIRTHPLACE (State or foreign country) <u>Fort Ashby, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Scott Crawford</u>				14. MOTHER'S MAIDEN NAME <u>Sally Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Miss Nellie Crawford Ft. Ashby, W. Va.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>44 dx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of heart</u> DUE TO (c) <u>Arteriosclerosis of heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia due to nephrosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7-10-11</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/16, 1958</u> , to <u>6/2, 1958</u> , that I last saw the deceased alive on <u>6/2, 1958</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 Greene Street, Cumberland, Md.</u> DATE SIGNED <u>6/2/58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. S.G. Weisman</u> <u>59 Greene Street, Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06324

Reg. Dist. No.

6326

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

54yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland, Md.

d. STREET ADDRESS

413 Race Street

IS RESIDENT
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First Middle Last
Elizabeth Etta Cunningham

4. DATE
OF
DEATH

Month Day Year
6 - 8 - 19 58

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 9, 1888

9. AGE (In years last birthday)

69 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self Employed

10b. KIND OF BUSINESS OR INDUSTRY

Grocery Store

11. BIRTHPLACE (State or foreign country)

Artemas, Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel Jay

14. MOTHER'S MAIDEN NAME

Agnes Barkman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO

212-32-8094

17. INFORMANT

Address

Dr. Orville Swartley, Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Heart Failure

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Arteriosclerotic heart disease

INTERVAL BETWEEN
ONSET AND DEATH
6 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

Benedict Skitarelic

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

Dr. Benedict Skitarelic

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

May 8, 1958

22a. BURIAL CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

6-11-58

22c. NAME OF CEMETERY OR CREMATORY

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR

JUN 10 '58

24b. REGISTRAR'S SIGNATURE

Artemas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6327

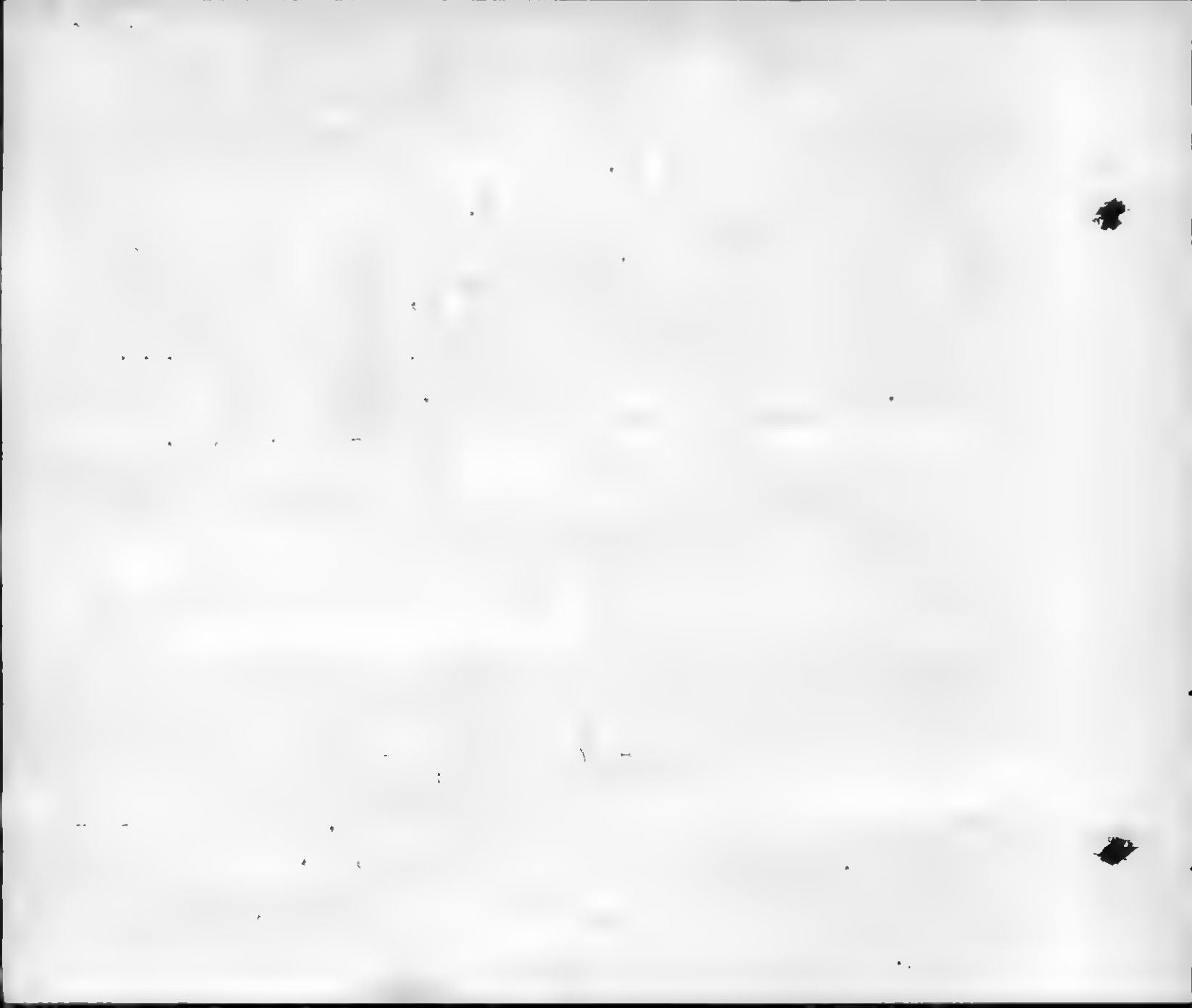
CERTIFICATE OF DEATH

06325

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 1/2 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. STREET ADDRESS RT. #1, VALLEY ROAD	
3. NAME OF DECEASED (Type or print) First FRANCES Middle R. Last DICK		4. DATE OF DEATH Month JUNE Day 22 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 30, 1921
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR: Months 36 Days 36 Hours 36 Min 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY FORD GARAGE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. DICK		14. MOTHER'S MAIDEN NAME RUTH I. HAUSMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215-16-4464	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 44 DUE TO Malignant Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 - 21 , 1958 , to 6 - 22 , 1958 , that I last saw the deceased alive on 6 - 21 , 1958 , and that death occurred at 2:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St.	
PHYSICIAN'S NAME (Type) DR. RALPH BALLIN		DATE SIGNED 6-22-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John . Hafer		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 27 '58		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 781 FAYETTE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last RALPH ELMER DIEBOLD		4. DATE OF DEATH Month Day Year JUNE 17 19 58		5 SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 17, 1886		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, also if retired) Retired Bartender		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY DIEBOLD (DECEASED)		14. MOTHER'S MAIDEN NAME Minnie Lewis (DECEASED)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT PATIENTS CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute myocarditis, generalized DUE TO (c) Coronary Heart Disease												INTERVAL BETWEEN ONSET AND DEATH 8 da. 10 yr. 10 yr.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, marked														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 28, 1958 to June 17, 1958 , that I last saw the deceased alive on June 17, 1958 , and that death occurred at 2:50 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 140 BEDFORD ST., CUMBERLAND, MD. DATE SIGNED 6/17/58																	
ACTUAL SIGNATURE James P. Hallinan M.D.				PHYSICIAN'S NAME (Type) JAMES P. HALLINAN, M.D.				140 BEDFORD ST., CUMBERLAND, MD.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/19/58				22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem				22d. LOCATION (City, town or county) (State) Cumberland Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.				24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE DATE					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8

17

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6329

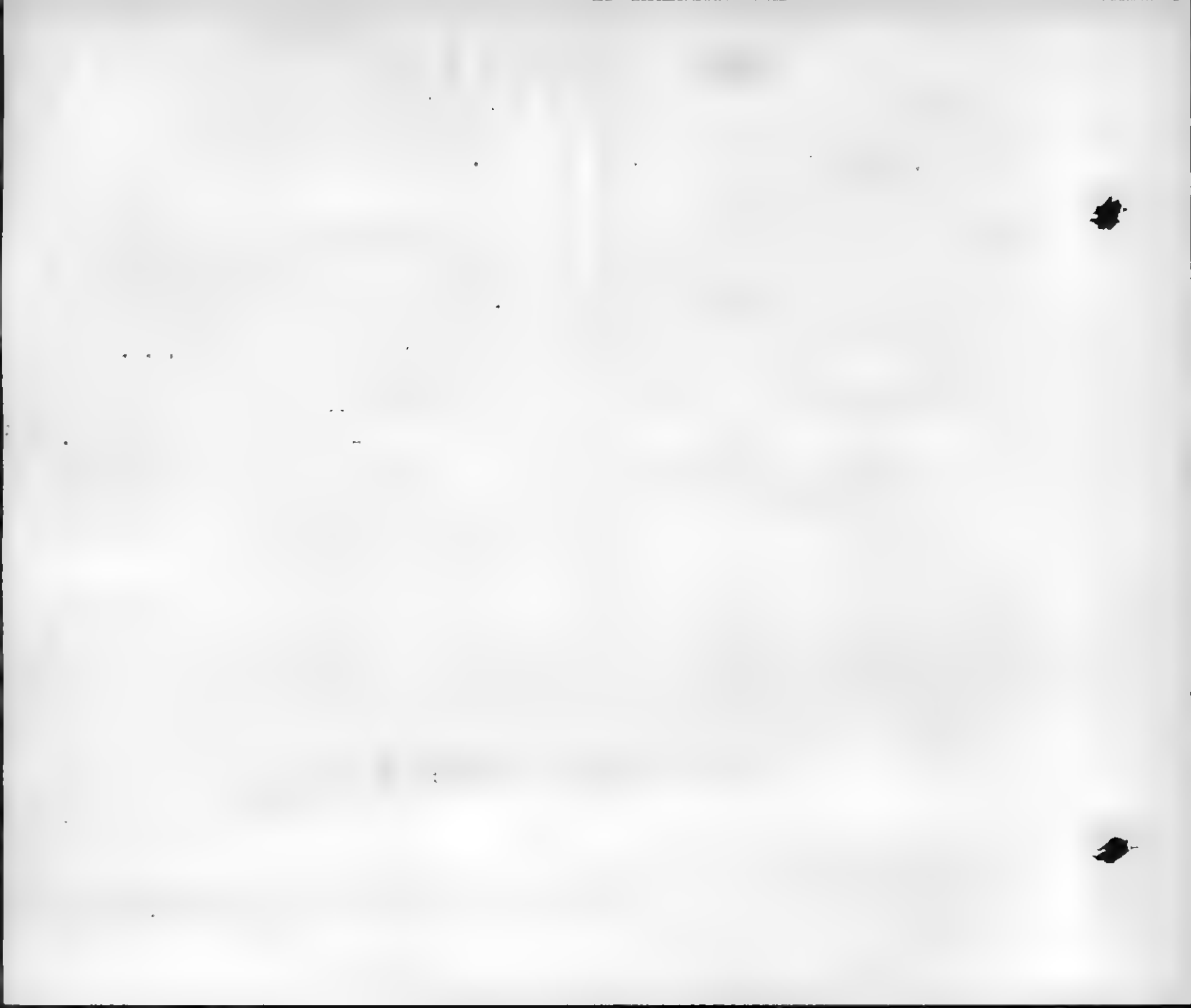
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. CUMBERLAND MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 21 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS MT. SAVAGE	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle EDITH Last DIETZ		4. DATE OF DEATH Month JUNE Day 23 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 18
9. AGE (In years last birthday) yrs 64		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDRA EMERICK		14. MOTHER'S MAIDEN NAME CLARA KENNEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - MEMORIAL & WARWICK AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Refrigerated Sarcoma. 158X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Intermittent 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to June 23, 1958 , that I last saw the deceased alive on June 22, 1958 , and that death occurred at 12:31 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William P. James M.D. 441 N. Center St 6-23-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William P. James, M.D. Cumberland MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or county) (State) Cumberland, Md. RD	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE JUN 26 '58		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

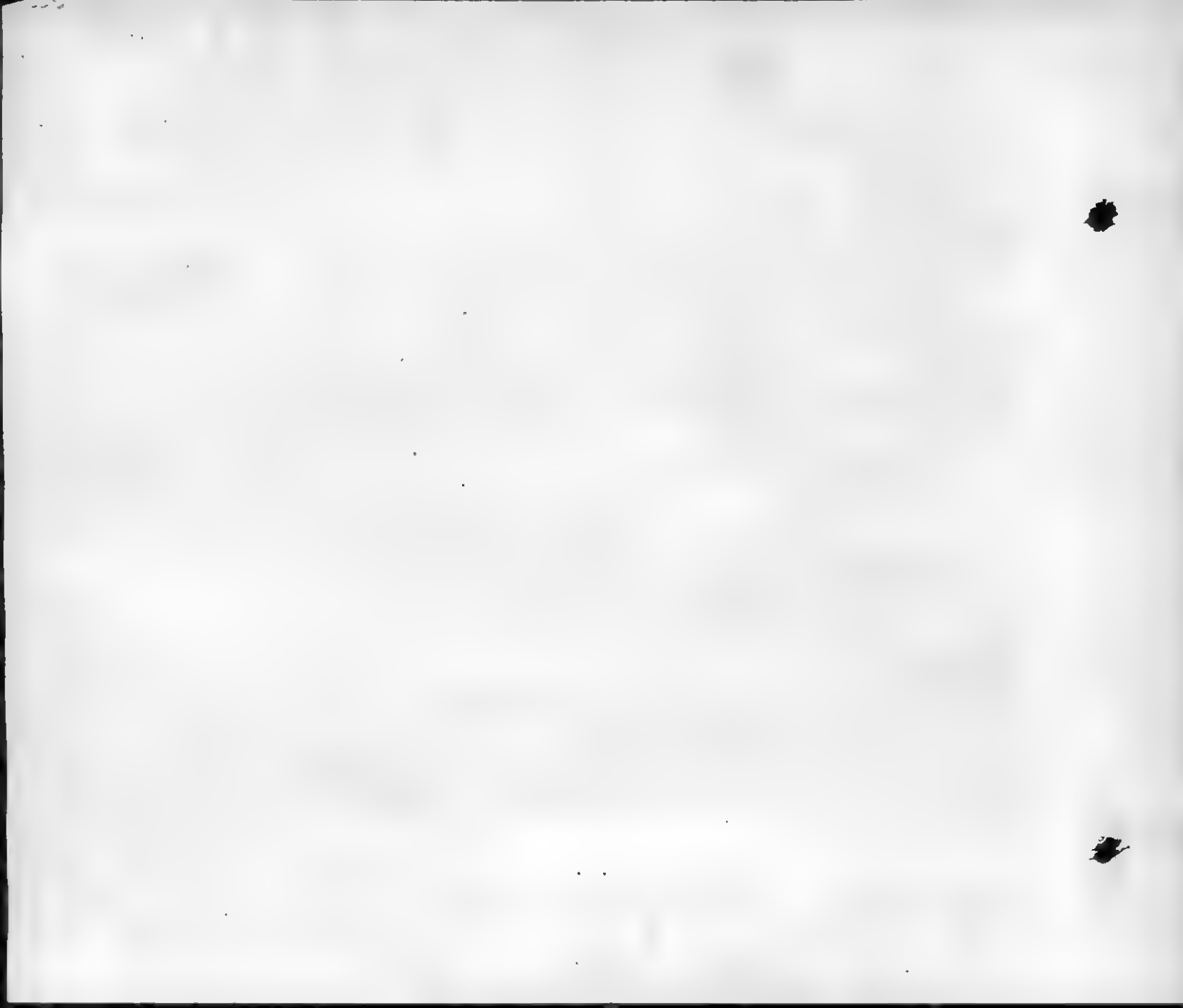
6330

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY in 1b years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 610 Memorial Avenue		e. STREET ADDRESS 610 Memorial Avenue		f. SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE ON A FARM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) WILBUR JAMES DIXON		4. DATE OF DEATH June 24, 1958		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1886		9. AGE (in years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Supervisor B & O Railroad		11. BIRTHPLACE (State or foreign country) Glenmore, New York		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Adomson Dixon		14. MOTHER'S MAIDEN NAME Eunice Stanford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna K. Dixon		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 24, 1958		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Westmoreland Cemetery		22d. LOCATION (City, town, or county) (State) Westmoreland, New York		23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 27 '58		24b. REGISTRAR'S SIGNATURE W. H. Search			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6376

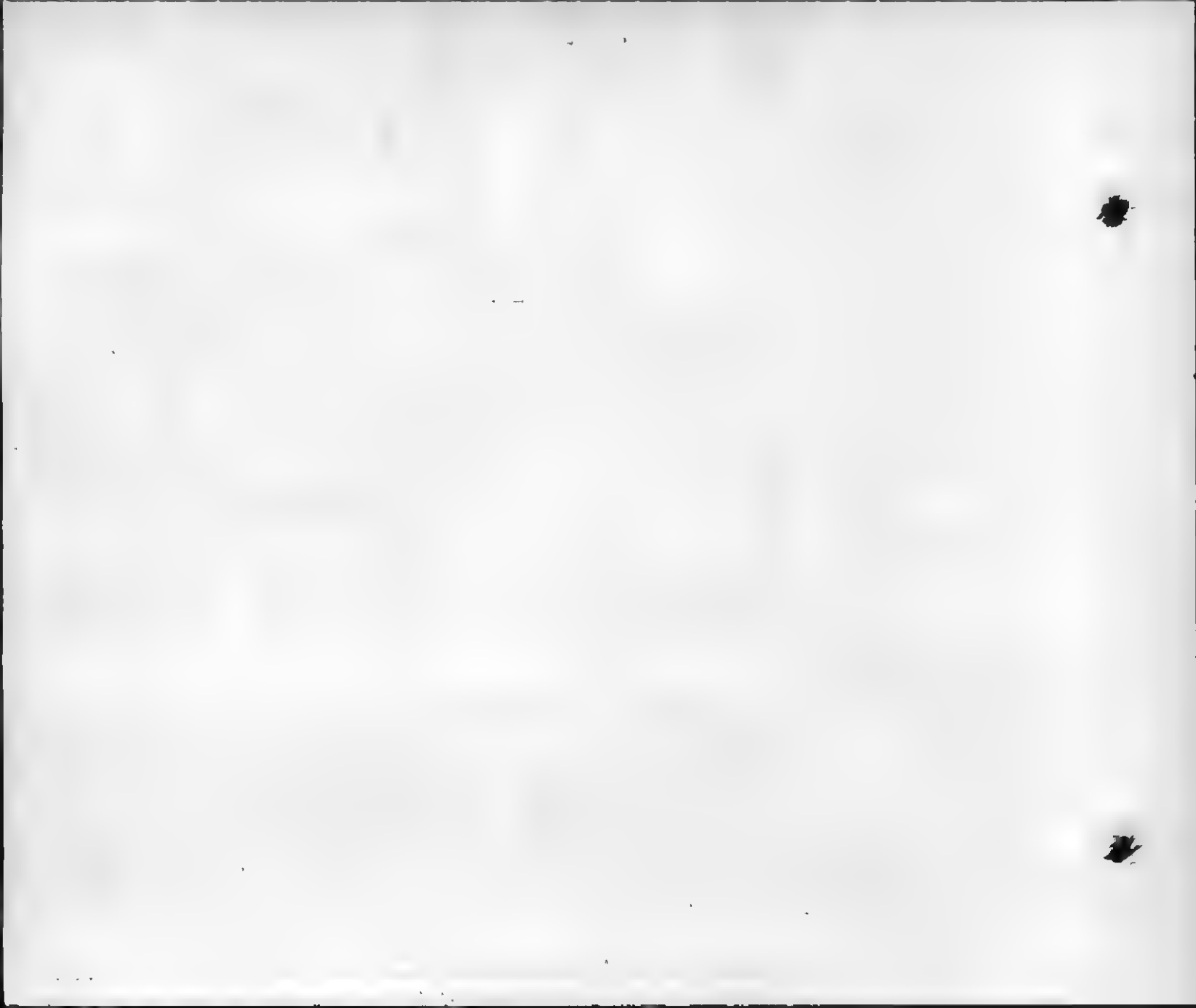
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hosnital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle (ARTZ) Last DREW		4. DATE OF DEATH Month JUNE Day 26 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1887
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Artz		14. MOTHER'S MAIDEN NAME Annie Chilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Harbert Allen, Rt. 1, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia (c) Septicemia		INTERVAL BETWEEN ONSET AND DEATH 3 mo Septicemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Seakites		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1 , 19 58 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W O M C Lane M D		ADDRESS (Street, city or town, state) E. Main St., DATE SIGNED June 27 1958	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-29-58	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6377

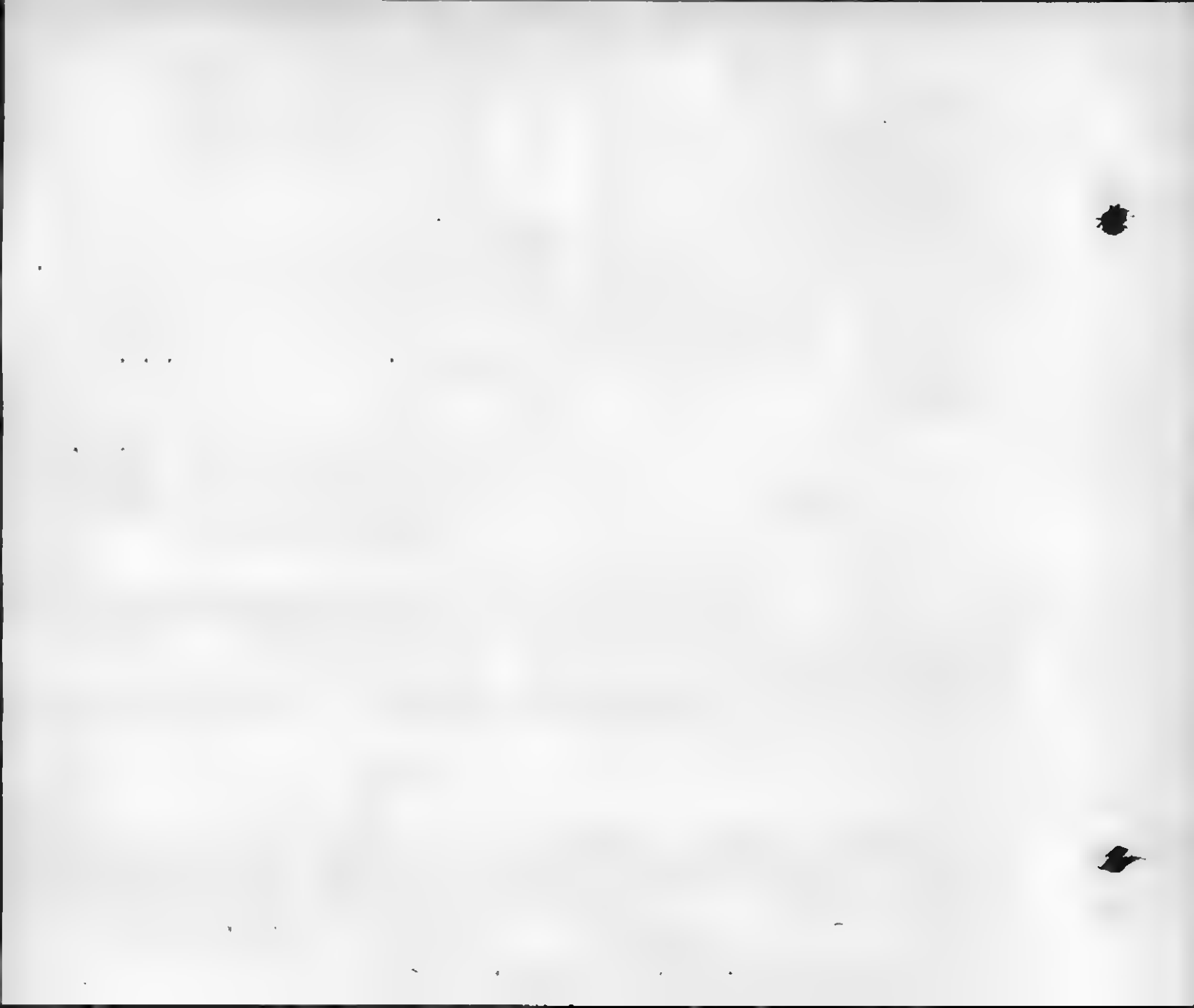
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 10 hrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Box 94, Carlos		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last DREW				4. DATE OF DEATH Month 6 Day 8 Year 19 58.			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-23-1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS 6 19 58.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carlos, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Thomas				14. MOTHER'S MAIDEN NAME Alice Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT Harold Drew, Box 94 (Carlos) Frostburg, Md. Address (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 422.1 DUE TO Circulatory Collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease - 10 yrs. (c) Diabetes Mellitus, uncontrolled 1 month							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 19 58 , to June 8, 19 58 , that I last saw the deceased alive on June 8, 19 58 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 B Roadway Frostburg, Md.			
DATE SIGNED 6/9/58							
PHYSICIAN'S NAME (Type) John B. Davis, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montecant				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06331

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>225 Columbia Street</u>		2. USUAL RESIDENCE (Where deceased lived f institution Residence before adm.ss.on) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> d. STREET ADDRESS <u>225 Columbia St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Josephine H. Edwards</u>		4. DATE OF DEATH <u>June 16 1958</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 30, 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u>		11. IF UNDER 24 HRS Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Alleg. Co., N. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>N. S. A.</u>		13. FATHER'S NAME <u>William F. Willison</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Hendrickson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Webster Edwards</u> Address <u>Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> DUE TO (b) <u>Arteriosclerotic C V disease</u> DUE TO (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute and Chronic Cholecystitis</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 16, 1958</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park Frostburg Md</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steinhilber</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>June 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6332

06332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 606 EDWARDS AVENUE	
3. NAME OF DECEASED (Type or print) ALBERT C. ESKIN		4. DATE OF DEATH Month JUNE Day 25 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9, 1908
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEWARK, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL ESKIN		14. MOTHER'S MAIDEN NAME ROSE Saslow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO 212-38-6539	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident --- Hemorrhage right side with Paralysis left side of body. DUE TO (b) 35ix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22 , 19 58 , to June 25 , 19 58 , that I last saw the deceased alive on June 25 , 19 58 , and that death occurred at 11:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 6/26/58			
ACTUAL SIGNATURE DR. S. JACOBSON		PHYSICIAN'S NAME (Type) Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1958	
22c. NAME OF CEMETERY OR CREMATORY East View Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO SPIRITUAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6333

CERTIFICATE OF DEATH

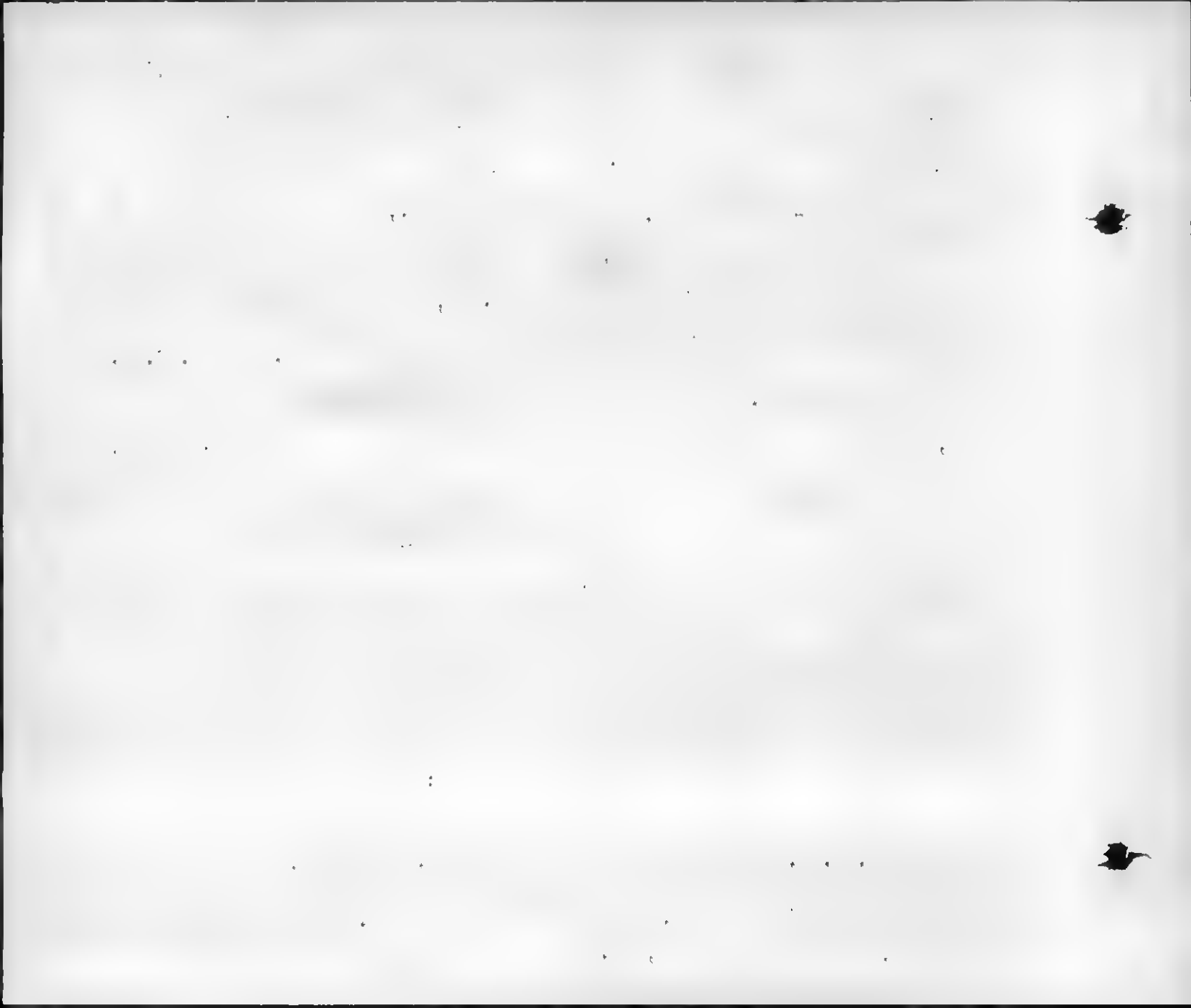
06333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY; d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALLE d. STREET ADDRESS Maple St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE Franklan EWALD		4. DATE OF DEATH Month Day Year JUNE 11 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 22, 1893
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) MARYLAND Balto.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM F. GEES		14. MOTHER'S MAIDEN NAME BESSIE Dunnigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4.20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sharp
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-10-1958 to 6-11-1958 , that I last saw the deceased alive on 6-11-1958 , and that death occurred at 6:11 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) W. F. Williams M.D. Cumberland Md. 6-12-58 DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS 122 S. Centre St.,			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/13/58	22c. NAME OF CEMETERY OR CREMATORY St. George Episcopal	22d. LOCATION (City, town, or county) (State) Mt. Savage, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUN 16 '58	24b. REGISTRAR'S SIGNATURE Alfred Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

66334

6334

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chamberland</u>		c. LENGTH OF STAY IN 1b <u>Spring Gap</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Gerdeman</u>		4. DATE OF DEATH Month Day Year <u>June 14 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9. 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Robert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Jane Frances (Arnold)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Patients Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Insufficiency</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd Ht Hypertension Cardiovascular Disease, Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-12</u> , 19 <u>58</u> , to <u>6-14</u> , 19 <u>58</u> that I last saw the deceased alive on <u>6-14</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>441 N. Center St</u> <u>6-14-58</u>			
ACTUAL SIGNATURE <u>William R. James</u>		M.D. <u>W. R. James</u>	
PHYSICIAN'S NAME (Type) <u>William R. James</u>		<u>Chamberland Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's + Paula</u>	22d. LOCATION (City, town, or county) (State) <u>Chamberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md</u>	
24a. REC'D BY REGISTRAR DATE <u>June 17 1958</u>		24b. REGISTRAR'S SIGNATURE <u>G. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6335

CERTIFICATE OF DEATH

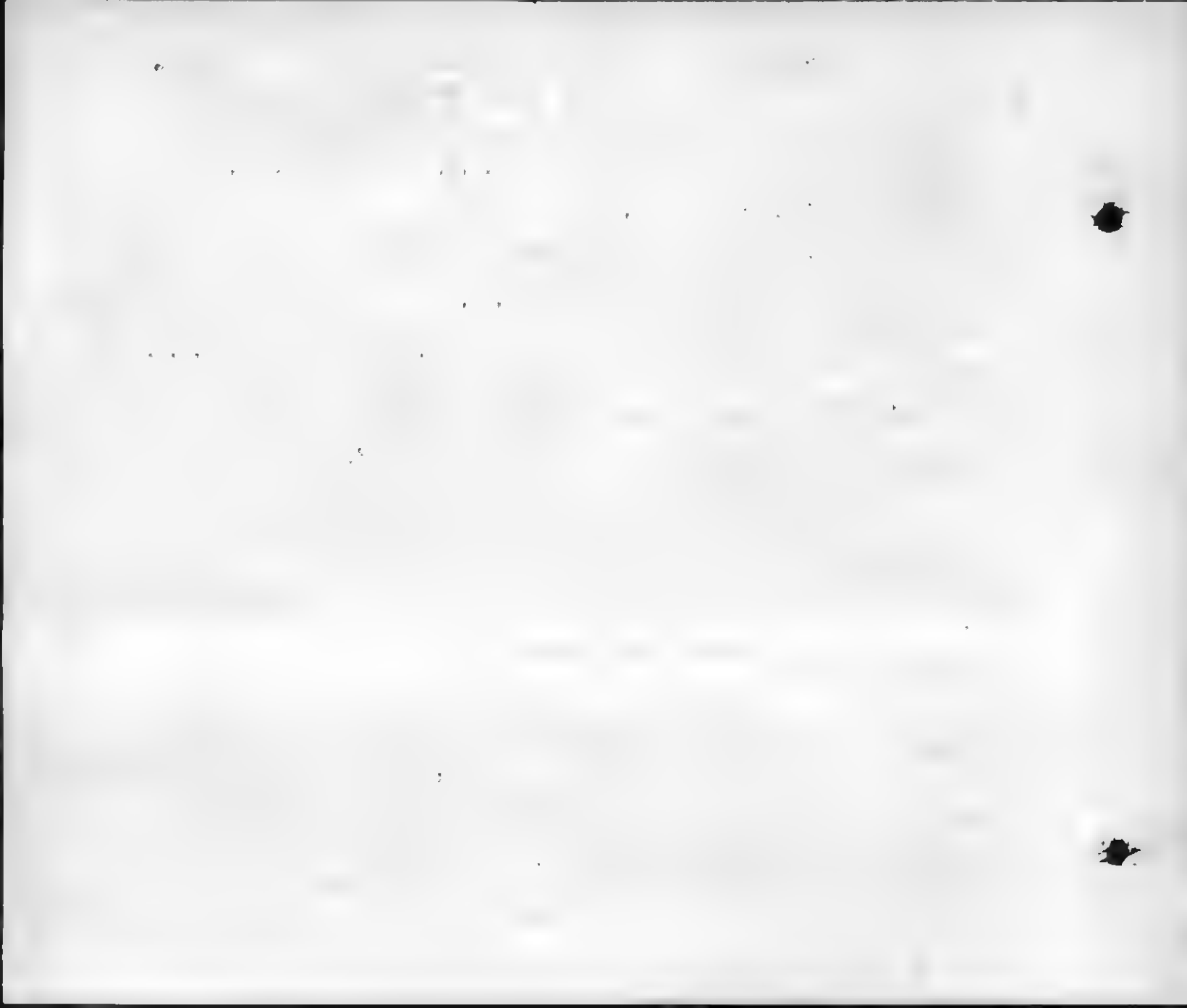
06335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b KX 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D.#3 CUMBERLAND, MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL GRAPES				4. DATE OF DEATH Month JUNE Day 29 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.28.58		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT E. GRAPES				14. MOTHER'S MAIDEN NAME VIVIAN RYAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 28 wks. - chorioamnionitis 162.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 13 late DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 28 June, 1958 , to 29 June, 1958 , that I last saw the deceased alive on 29 June, 1958 , and that death occurred at 9:25 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Fuller B. Whitworth 29 June 58 PHYSICIAN'S NAME (Type) Fuller B. Whitworth							
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 1, 1958		Sunset Memorial Park		Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hefer, Cumberland, Md				24a. REC'D BY REGISTRAR DATE JUL 3 '58		24b. REGISTRAR'S SIGNATURE Chas. E. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

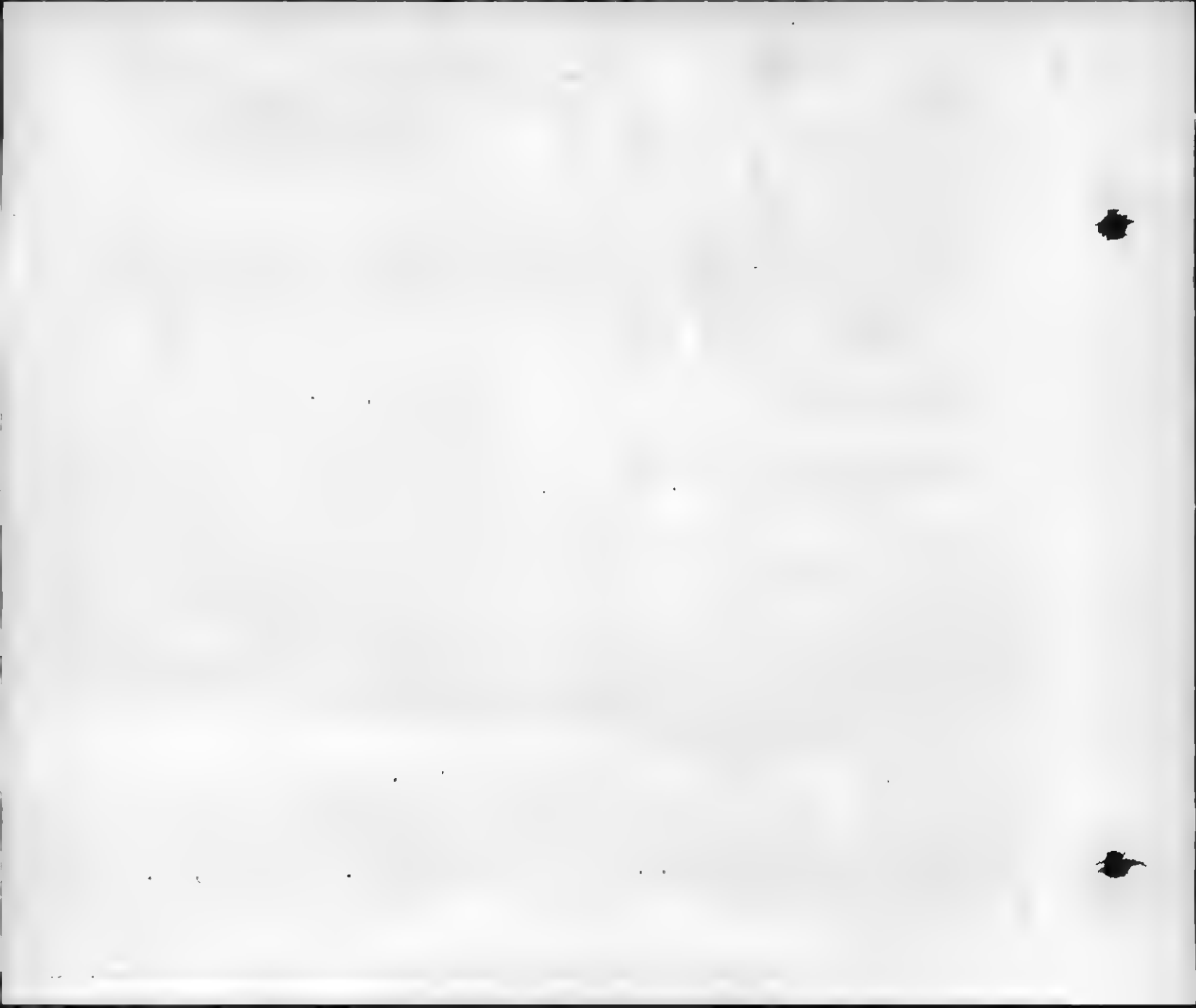


6336

CERTIFICATE OF DEATH

Reg. Dist. No. 06336

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		d. STREET ADDRESS <u>1000 E. 1st St.</u>	
3. NAME OF DECEASED (Type or print) First <u>JENI</u> Middle <u>RAE</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22, 1958</u>
9. AGE (In years lost birthday) yrs. <u>23</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT BLAIN GREEN</u>		14. MOTHER'S MAIDEN NAME <u>HAZEL V. KNOX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>PATIENTS CLERK</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/4</u> , 19 <u>58</u> , to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/4</u> , 19 <u>58</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>55 GRANTVILLE, CARROLL CO., MD.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ELIZABETH BRINGS, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE CARROLL CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman</u>		24a. REC'D BY REGISTRAR <u>—</u> ADDRESS <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>JUN 8 '58</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6337

CERTIFICATE OF DEATH

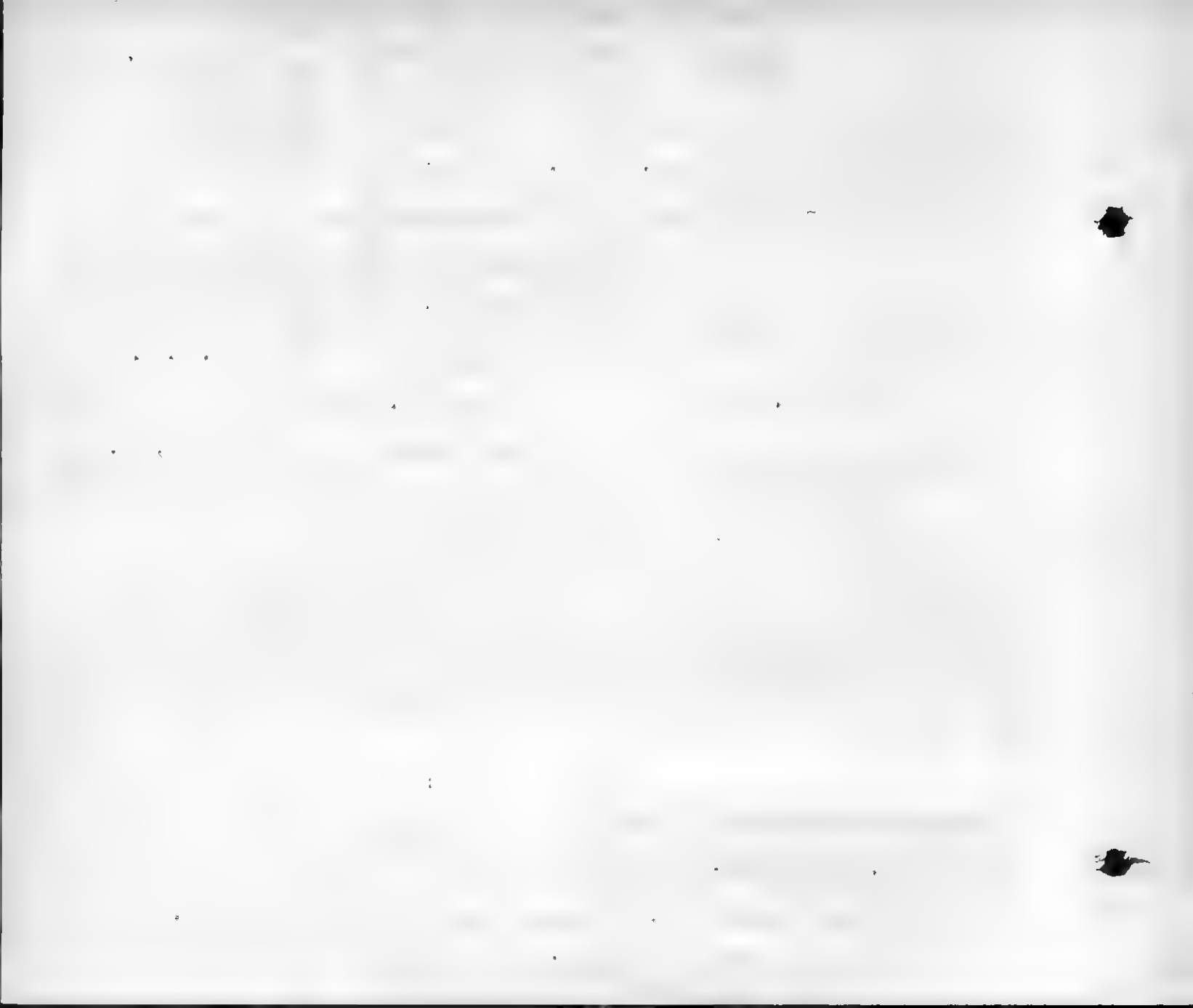
Reg. Dist. No.

06337

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 HRS. 8 MINS.		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE				e. STREET ADDRESS 122 INDEPENDENCE STREET				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY		First BOY		Middle HARBAUGH		Last HARBAUGH		4. DATE OF DEATH Month JUNE Day 10 Year 19 58	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 10, 1958		9. AGE (In years last birthday) yrs. 5 Months 8 Days 5 Hours 8 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS E. HARBAUGH				14. MOTHER'S MAIDEN NAME BETTY D. KERNS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Herniation of Abdominal Viscera into Left Chest DUE TO (c) Complete Absence of Left Diaphragm								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 June 19 58 to 10 June 19 58 that I last saw the deceased alive on 10 June 19 58 , and that death occurred at 3:45 PM , from the causes and on the date stated above.									
ACTUAL SIGNATURE Leland Ransom				ADDRESS (Street, city or town, state) 63 Grease St, Camb, Md DATE SIGNED June 12 1958					
PHYSICIAN'S NAME (Type) DR. LELAND RANSOM									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUN 16 '58		24b. REGISTRAR'S SIGNATURE Quinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

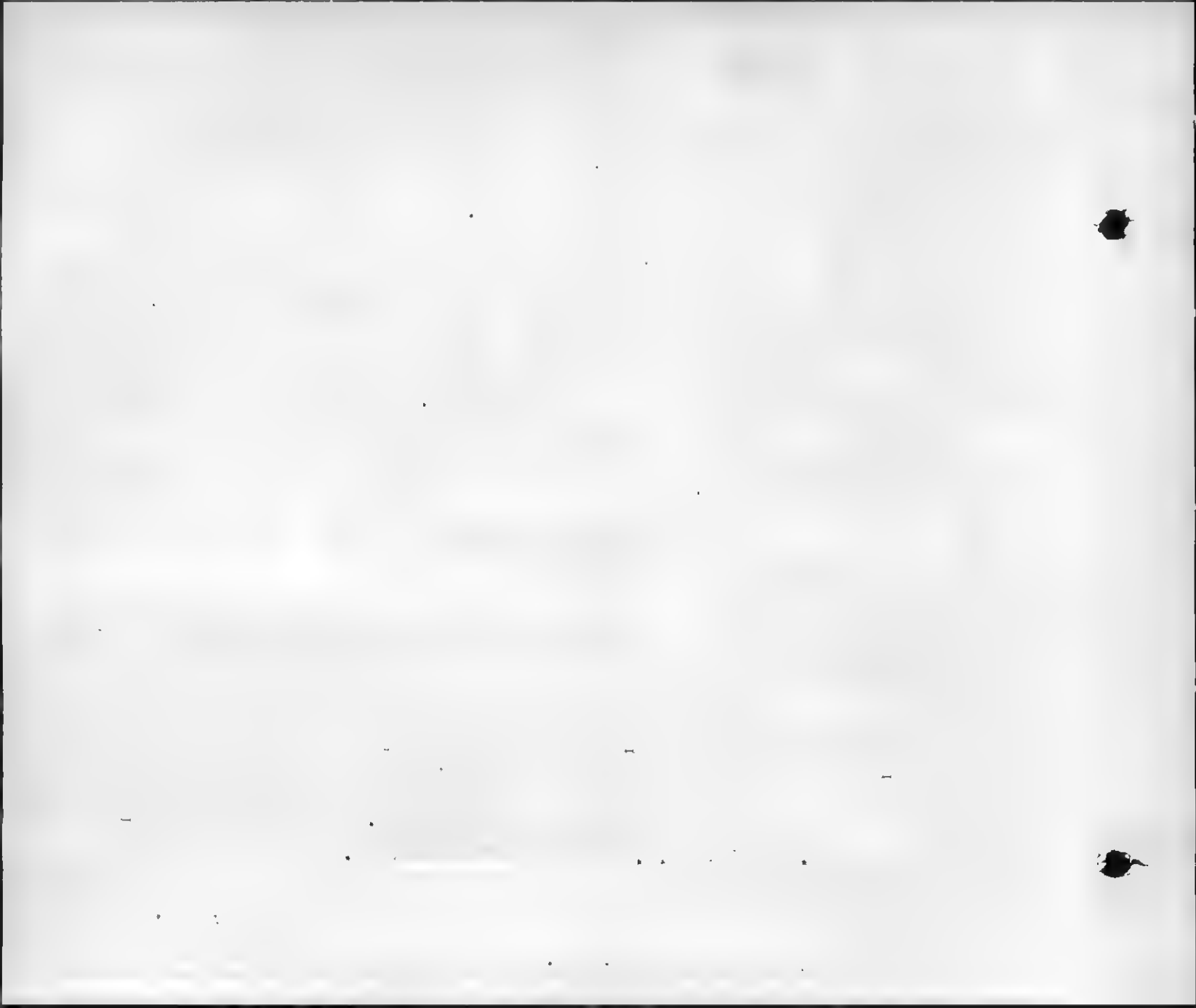
Reg. Dist. No. **06338**

6338

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Rt. # 2			
3. NAME OF DECEASED (Type or print) First Lewis Middle W. Last Hartsock				4. DATE OF DEATH Month June Day 4 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/96	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY. USA	
13. FATHER'S NAME Ensley Hartsock				14. MOTHER'S MAIDEN NAME Clara W. Willison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 213 24 6029		17. INFORMANT Patients Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-11 , 54 , to 6-4 , 1958 , that I last saw the deceased alive on 6-4 , 1958 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph W. Ballin M.D.				ADDRESS (Street, city or town, state) 62 Greene St.		DATE SIGNED 6-5-58	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6393

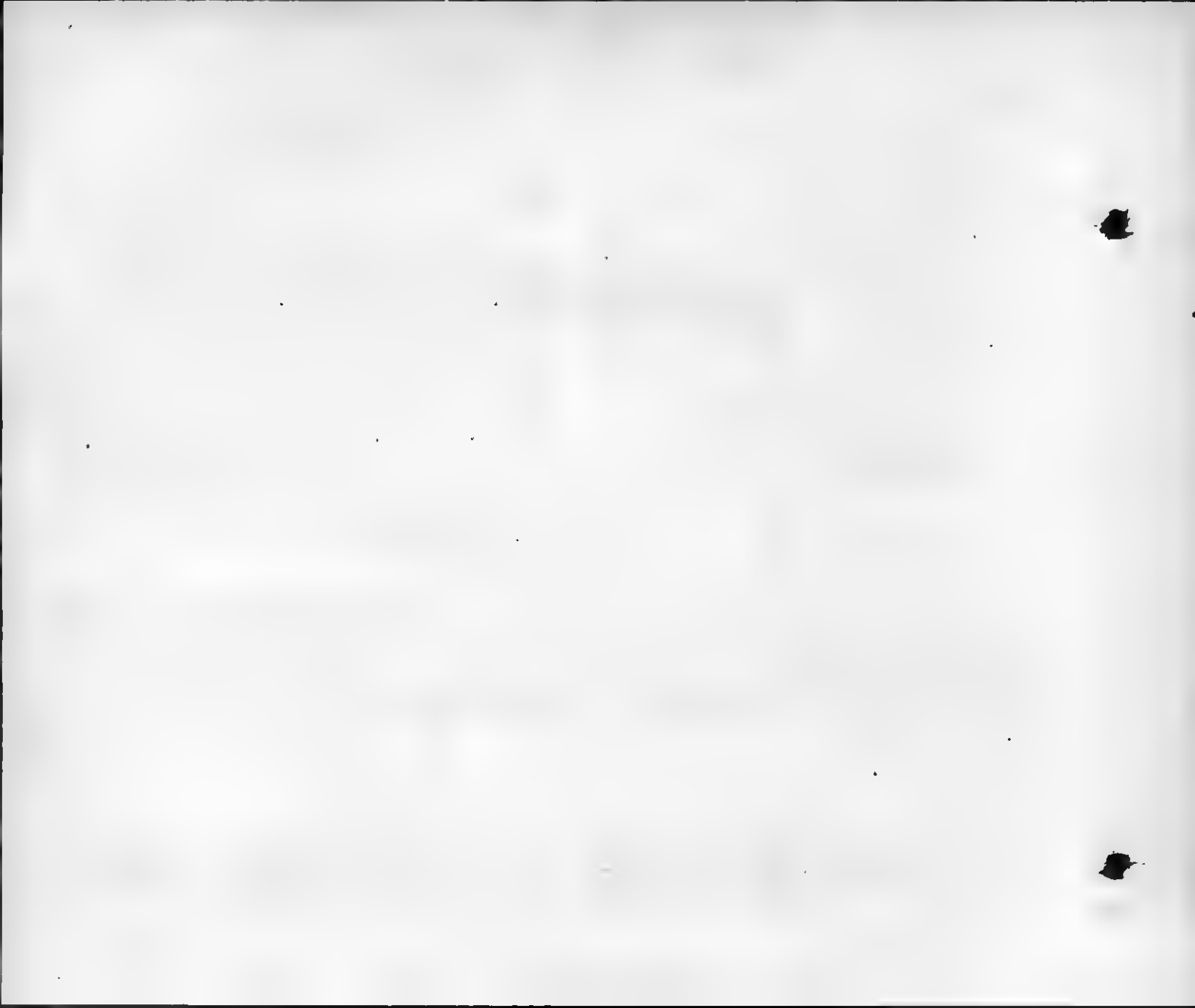
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARTHA Middle S. Last HENCKEL		4. DATE OF DEATH Month June Day 6 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1869
9. AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months 8 Days 1 Hours 0 Min 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Valentine Henckel		14. MOTHER'S MAIDEN NAME Catherine Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		17. INFORMANT Miss Grace Henckel, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 14 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1958 , to June 6, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. O. McLane		ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md.	
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		DATE SIGNED June 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-9-1958	22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR JUN 9 '58		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6394

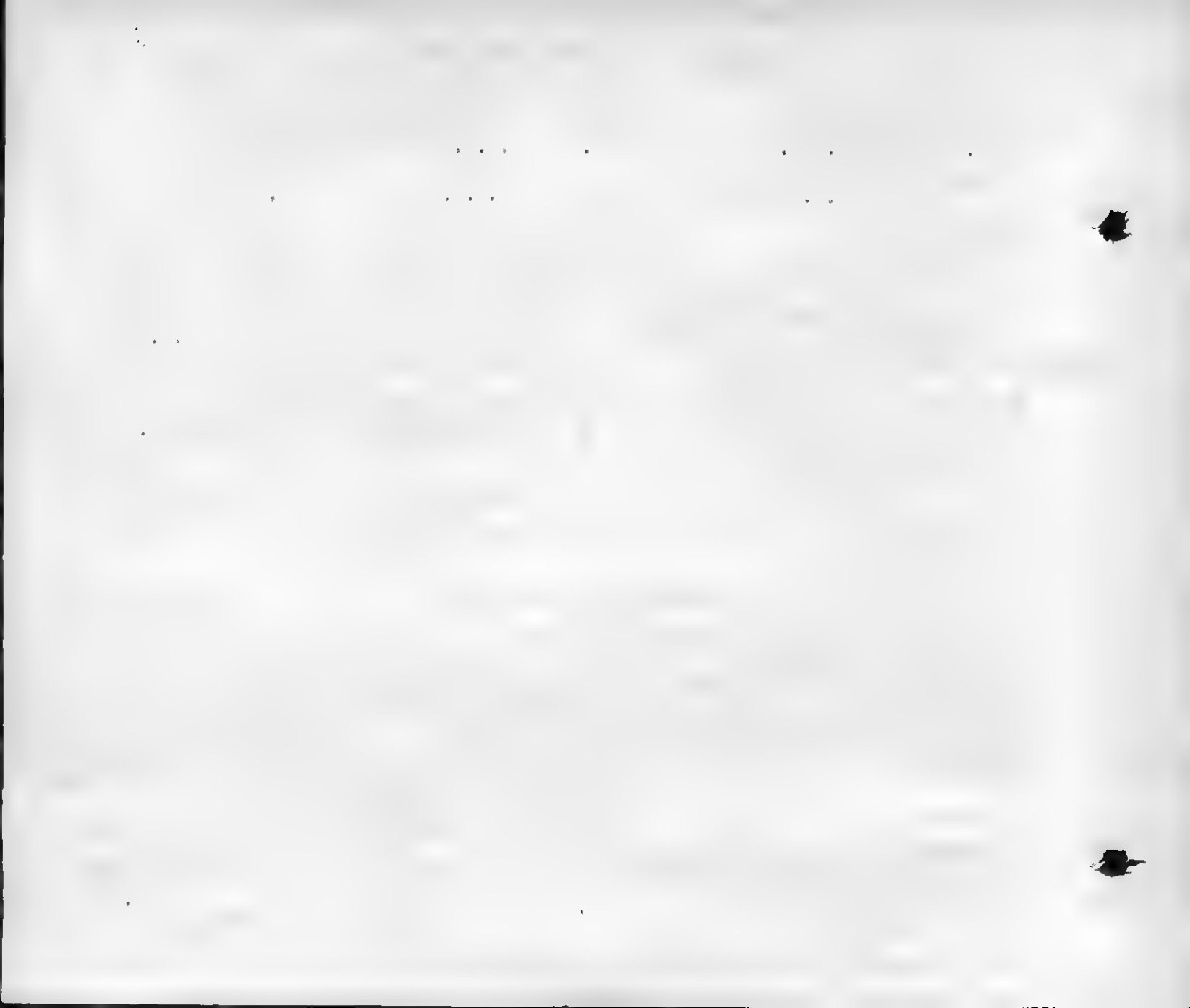
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 1 Barton, Md.				c. LENGTH OF STAY IN 1b 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION R.F.D. 1 Barton, Md				e. STREET ADDRESS R.F.D. 1 Barton, Md.			
3. NAME OF DECEASED (Type or print) EXENIA First BELLE Middle HILL Last				4. DATE OF DEATH Month June Day 3 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1878		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Delaplain Moreland				14. MOTHER'S MAIDEN NAME Mary Kay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Allen Hill Address Piedmont, W.Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema						INTERVAL BETWEEN ONSET AND DEATH 16 Years 10 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 3, 1958 , to June 3, 1958 , that I last saw the deceased alive on June 3, 1958 , and that death occurred at 9:11 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul R. Wilson M.D.				ADDRESS (Street, city or town, state) Piedmont W.Va DATE SIGNED 6-4-58			
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Sharps Cem.		22d. LOCATION (City, town, or county) (State) Fair Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. Boral ADDRESS Westernport, Maryland				24a. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE W. B. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6339

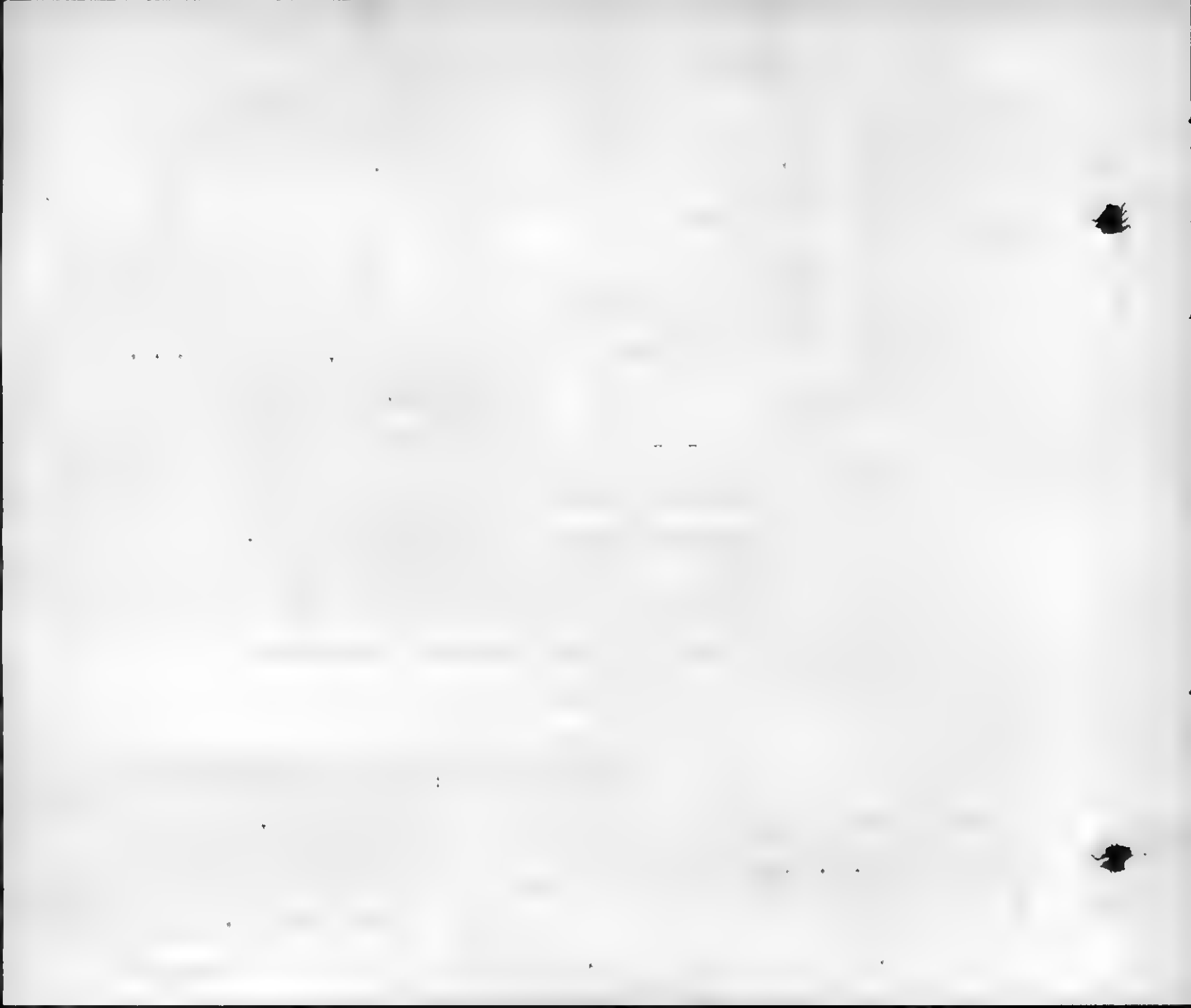
CERTIFICATE OF DEATH

06341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 65 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS THE DINGLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle HIRSH Last HIRSH				4. DATE OF DEATH Month 6 Day 30 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/3/1879	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours 15 Min 00		11. IF UNDER 24 HRS Months 7 Days 8 Hours 15 Min 00		12. IF UNDER 24 HRS Months 7 Days 8 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant				10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HIRSH, JOSEPH			
14. MOTHER'S MAIDEN NAME BAMBERGER, LINA Bamberger				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO 220-30-8347				17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Left Ventricular Failure 4x0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Fibrosis and Coronary Arteriosclerosis DUE TO (c) 15 years							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcified Aorta							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 26 , 19 58 , to June 30 , 19 58 , that I last saw the deceased alive on June 30 , 19 58 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St. DATE SIGNED PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1958		22c. NAME OF CEMETERY OR CREMATORY Last View Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6340

CERTIFICATE OF DEATH

06342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>157 Polk Street</u>				d. STREET ADDRESS <u>157 Polk Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Thomas</u> Last <u>Hoban</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/21/1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Allegany Bell Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas J. Hoban</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-30-1620</u>		17. INFORMANT Address <u>Mrs. Nellie Hoban Cumberland Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary heart Disease</u> DUE TO (c) <u>none</u>							<u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>February 24, 1958</u> to <u>June 23, 1958</u> , that I last saw the deceased alive on <u>June 23, 1958</u> , and that death occurred at <u>1:20 P.</u> M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>140 Beafora St. Cumb. Md.</u>				DATE SIGNED <u>6-24-58</u>			
ACTUAL SIGNATURE <u>James P. Hallinan M.D.</u>							
PHYSICIAN'S NAME (Type) <u>James P. Hallinan M. D.</u>				<u>Cumberland, Maryland.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arden Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6378

CERTIFICATE OF DEATH

Reg. Dist. No.

06343

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD (RURAL)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MILLER'S HOSPITAL</u>				d. STREET ADDRESS <u>RT 1 BOX 237</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL</u> <u>HEBEL</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>5</u> <u>19</u> <u>58</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 2, 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID E. HEBEL</u>				14. MOTHER'S MAIDEN NAME <u>CAROL ANN KIRK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>FATHER RT 1 FRANKFORD MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET OF DEATH <u>5 AM 1958</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INFANTILE PR-LIA LACTARIUS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 5, 1958</u> to <u>JUNE 5, 1958</u> , that I last saw the deceased alive on <u>JUNE 5, 1958</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>MARTIN M. ROYSTER M.D.</u>				DATE SIGNED <u>6/5/58</u>			
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROYSTER M.D.</u>				<u>FRANKFORD MD.</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ALLEGANY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DAVID E. HEBEL</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6379

CERTIFICATE OF DEATH

Reg. Dist. No.

06344

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Hammond		d. STREET ADDRESS 207 Hammond	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elsie First Belle Middle Howe Last		4. DATE OF DEATH Month June Day 19 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1887
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Ravenscroft		14. MOTHER'S MAIDEN NAME Mary Whorrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT William Howe		Address Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Artery Disease 440.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) old posterior infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 weeks unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Piedmont, W. Va.
20f. (City or town) Piedmont, W. Va.		(County) (State)	
21. I certify that I attended the deceased from May 27, 1958 , to June 19, 1958 , that I last saw the deceased alive on June 15, 1958 , and that death occurred at 4:35 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED June 21, 1958			
ACTUAL SIGNATURE Paul R. Wilson M.D.		DATE SIGNED June 21, 1958	
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 22, 1958	22c. NAME OF CEMETERY OR CREMATORY Nethkin Hill Cem.	22d. LOCATION (City, town, or county) (State) Elk Garden W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE ES. Bond		ADDRESS Westernport, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 23 '58		24b. REGISTRAR'S SIGNATURE Chas. E. Bond	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

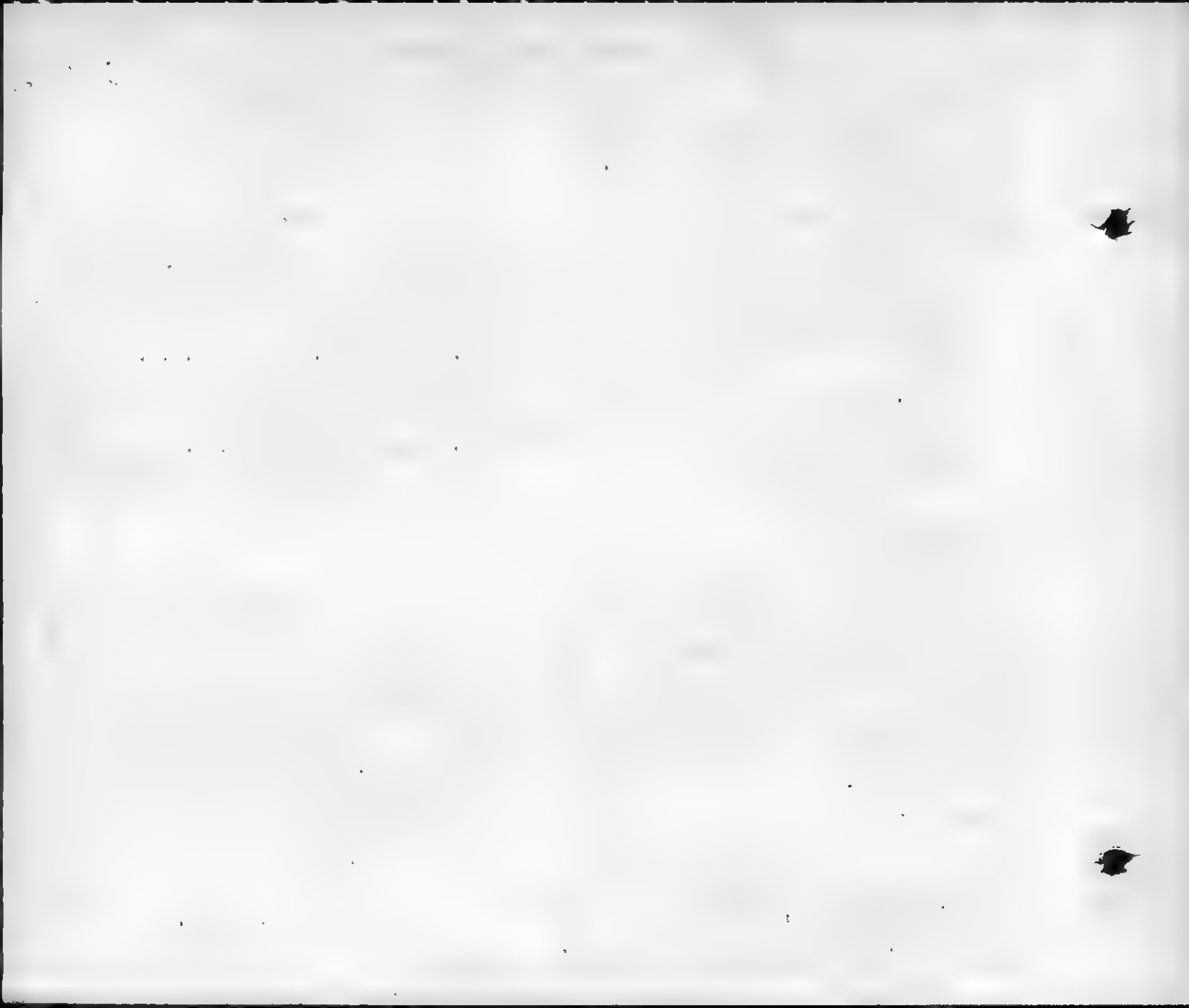
6341

CERTIFICATE OF DEATH

06345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>61 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Jacob</u> Last <u>Jacob</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min <u>58</u>	IF UNDER 24 HRS Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Savage, Md.</u>	
13. FATHER'S NAME <u>Hugh A. McMullen</u>				14. MOTHER'S MAIDEN NAME <u>Anna Mulledy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>William C. Jacob</u> Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>LUNGS, LIVER, CARCINOMATOSIS, GENERAL, PLEURA</u> DUE TO <u>Adenocarcinoma left breast removed Oct 1956</u> DUE TO <u>Adenocarcinoma left breast removed Oct 1956</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>58</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>59 Green St</u>	
21. I certify that I attended the deceased from <u>Jan 1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>11:58 p.m.</u> from the causes and on the date stated above				20f. (City or town) <u>Pittsburgh, Pa.</u>		20g. (County) <u>Allegheny</u>	
21. ACTUAL SIGNATURE <u>S. G. WEISTMAN</u> M.D.				21. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u>		21. DATE SIGNED <u>6/6/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				23. ADDRESS <u>Cumberland, Md.</u>		24. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
24. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>				24. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6342

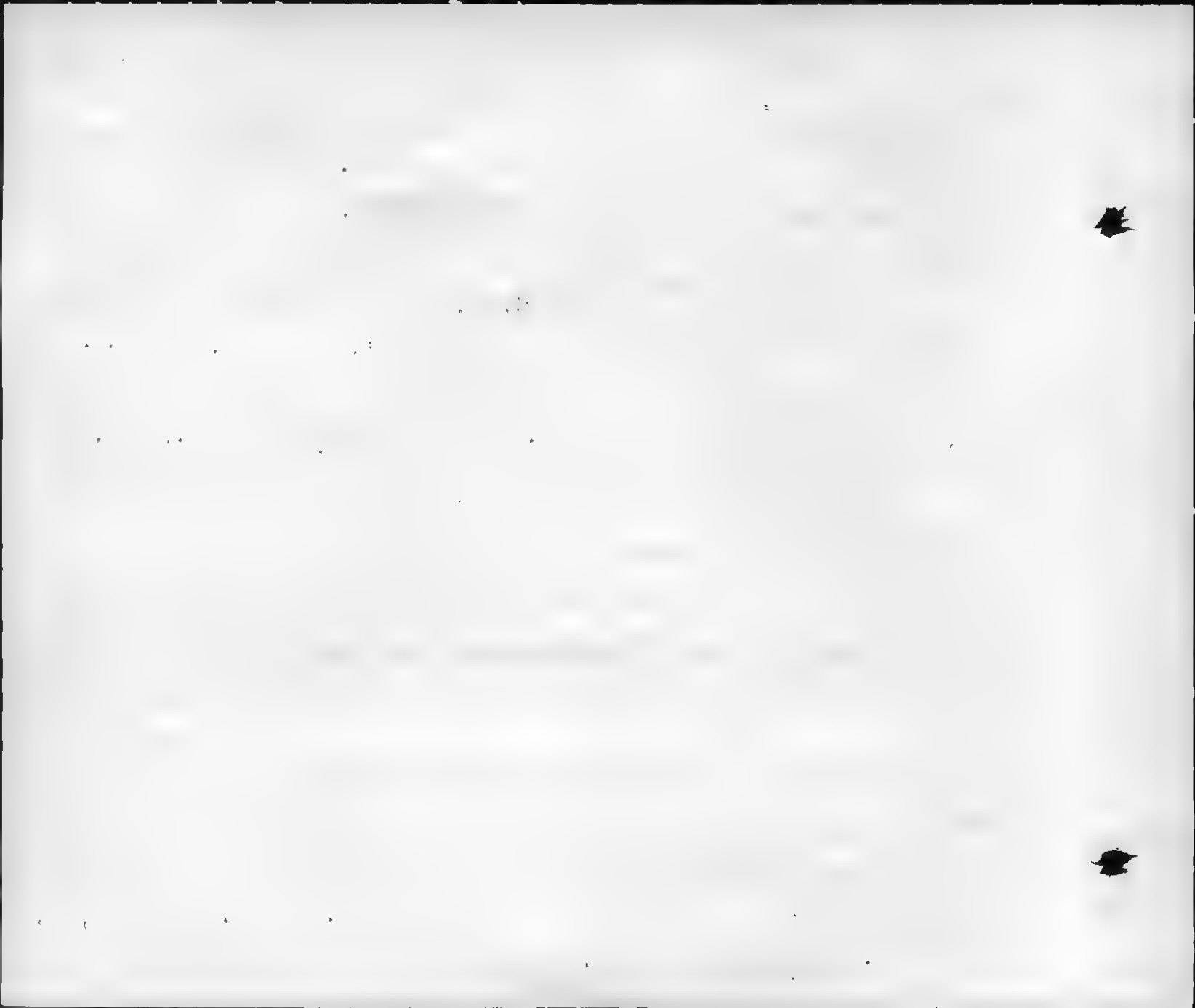
CERTIFICATE OF DEATH

06346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ada Middle Johnson Last Johnson		4. DATE OF DEATH Month 6 / Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1879
9. AGE (In years last birthday) 78 yrs		IF UNDER 1 YEAR Months 7 Days 13 Hours 13 M.in 13	IF UNDER 24 HRS Months 7 Days 13 Hours 13 M.in 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania, Bedford Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milton Brotemarkle		14. MOTHER'S MAIDEN NAME Mary Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Nellie Taylor 311 Pulaski St., Cumb. Md.		Address Patient's chart.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) Arteriosclerosis - Hypertension			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-16 , 19 58 to 6-26 , 19 58 , that I last saw the deceased alive on 6-25 , 19 58 , and that death occurred at 2:30 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 441 N. Centre St. N. Cumberland Md. DATE SIGNED 6-26-58			
ACTUAL SIGNATURE William P. Jones M.D.		PHYSICIAN'S NAME (Type) William P. Jones	
22a. BURIAL, CREMAT ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/58	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Pike nr. Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 30 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6343

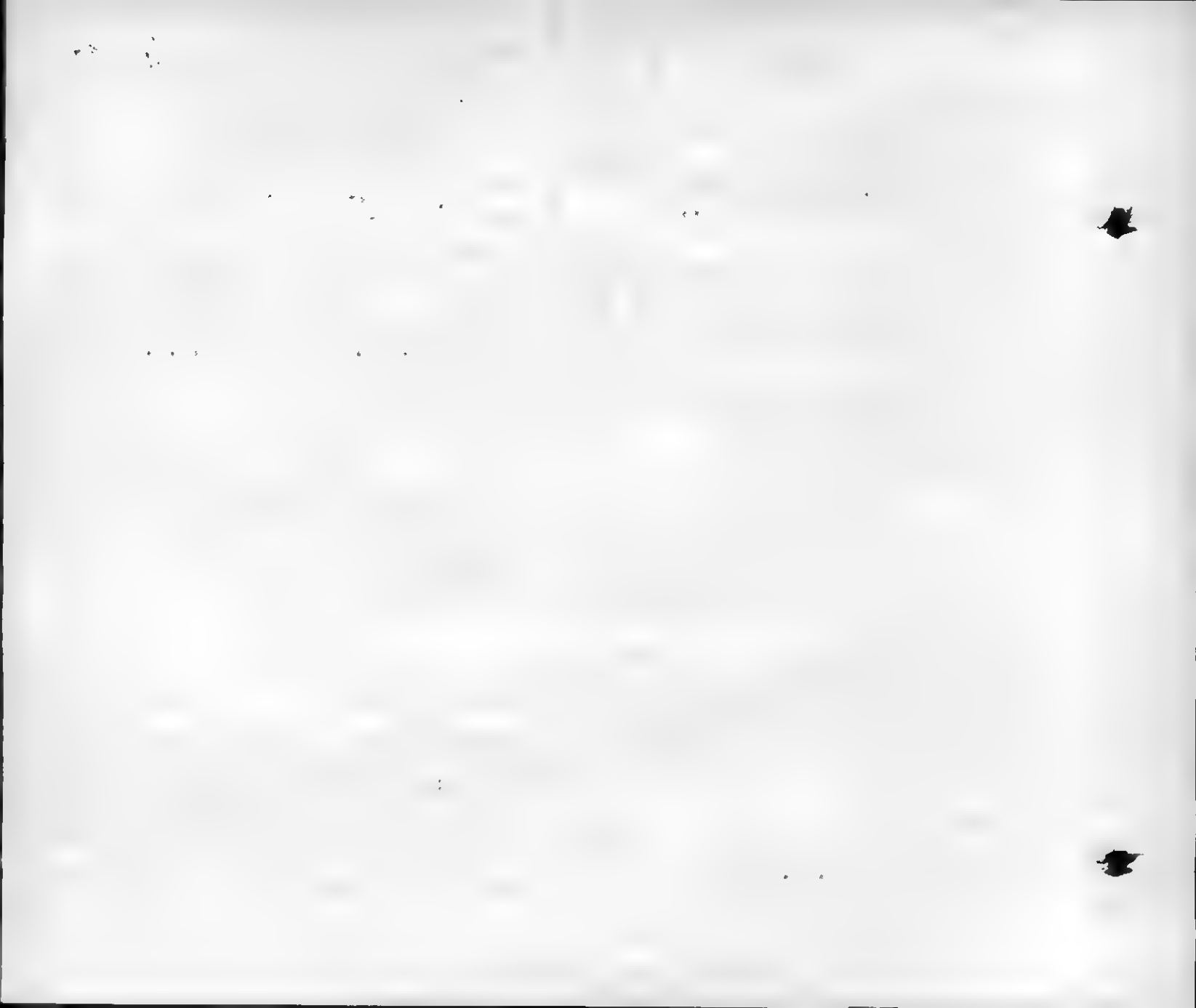
CERTIFICATE OF DEATH

Reg. Dist. **06347**

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS RT. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle M Last JONES				4. DATE OF DEATH Month JUNE Day 11 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30	
9. AGE (In years last birthday) yrs. 63		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MIDLAND, MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME CHARLES RICE				14. MOTHER'S MAIDEN NAME MARY EDWARDS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis genit 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH several Mo. ? 12 Mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from MAY 30 , 19 58 , to JUNE 11 , 19 58 , that I last saw the deceased alive on JUNE 11 , 19 58 , and that death occurred at 10:05 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. Cumberland, Md.		DATE SIGNED 6/13/58			
PHYSICIAN'S NAME (Type) A. J. MIRKIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-58		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal				ADDRESS Westernport Md		24a. REC'D BY REGISTRAR DATE JUN 17 '58	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6344

CERTIFICATE OF DEATH

Reg. Dist. No.

06348

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart</u>				d. STREET ADDRESS <u>316 Park Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>Mae</u> Last <u>Kaylor</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1899</u>	
9. AGE (in years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Thomas, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas Dornon</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Barker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Eugene Oxier</u> Address <u>Ridgeley, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma cervix c</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis metastases generalized</u> DUE TO (c) <u>intestinal obstruction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1/58</u> 19 <u>58</u> to <u>6/9</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/8/58</u> 19 <u>58</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md.</u> DATE SIGNED <u>6/1/58</u>							
ACTUAL SIGNATURE <u>George M. Simons</u> M.D. <u>128 W. Main St</u>							
PHYSICIAN'S NAME (Type) <u>Dr. George M. Simons</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Deane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06349

Reg. Dist. No.

6395

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Picardy Rural</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Picardy Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John H. Kenney</u>		4. DATE OF DEATH <u>June 20 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1903 55 yrs</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Kenney</u>		14. MOTHER'S MAIDEN NAME <u>Clara Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		17. INFORMANT <u>Police</u> Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitaralic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitaralic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Allegany Co. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumb. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 26 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Albert Couch</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06350

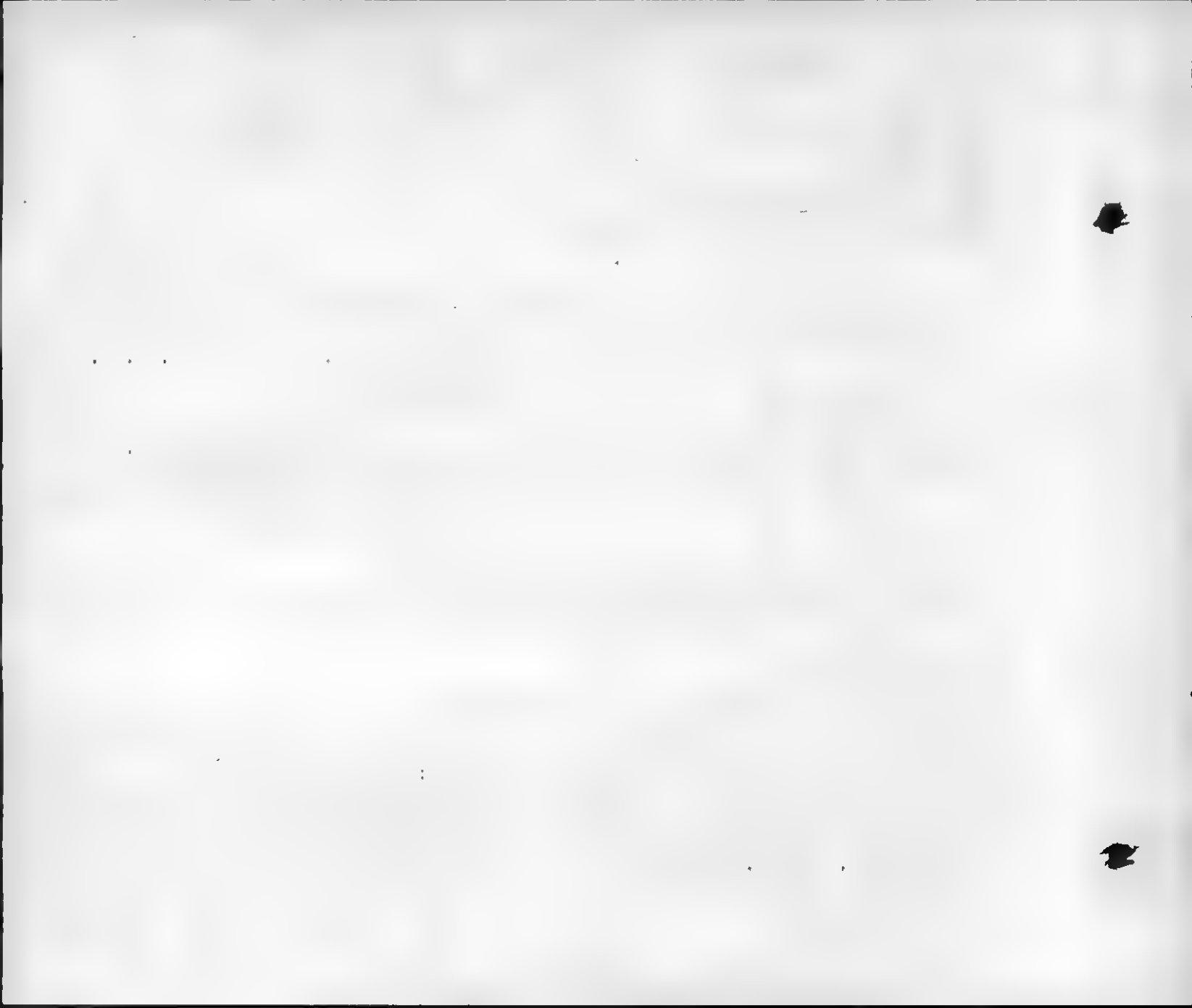
6345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE				d. STREET ADDRESS 53 BOONE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle T. Last KOLB				4. DATE OF DEATH Month JUNE Day 2 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 2, 1898		9. AGE (In years last birthday) 59 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FREDERICK KOLB				14. MOTHER'S MAIDEN NAME KATTY COOK SHAFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes War I		16. SOCIAL SECURITY NO. 705-05-4611		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 25, 1958 , to June 2, 1958 , that I last saw the deceased alive on June 2, 1958 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/3/58							
ACTUAL SIGNATURE Clay E. Durrett M.D.		23a. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.					
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22b. DATE THEREOF 6-6-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23b. REC'D BY REGISTRAR DATE JUN 5 '58		24b. REGISTRAR'S SIGNATURE Alfred...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 99 Narrows Park - Cumb. Md			c. LENGTH OF STAY IN 1b 10 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 99 Narrows Park - Cumberland, Md			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 99 Narrows Park - Cumberland, Md		
3. NAME OF DECEASED (Type or print) Milton Dicken Lashley			4. DATE OF DEATH Month June Day 9 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 23, 1877		9. AGE (In years last birthday) 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired railroad laborer Railroad		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S.	
13. FATHER'S NAME Robert Lashley			14. MOTHER'S MAIDEN NAME Dorcas Robinette		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Rhoda Lashley Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enlarged prostate necessitating catheter drainage					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 12, 1958 to June 9, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE R. W. Treva		M.D. Cumberland, Maryland		DATE SIGNED 6/11/58	
PHYSICIAN'S NAME (Type) R. W. TREVA, M.D., JR.		Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/58		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	
22d. LOCATION (City, town, or county) Cumberland		22e. (State) Maryland		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland, Maryland		24a. RECEIVED BY REGISTRAR JUN 12 1958	
24b. REGISTRAR'S SIGNATURE W. E. S. S.		DATE JUN 12 1958			



CERTIFICATE OF DEATH

6347

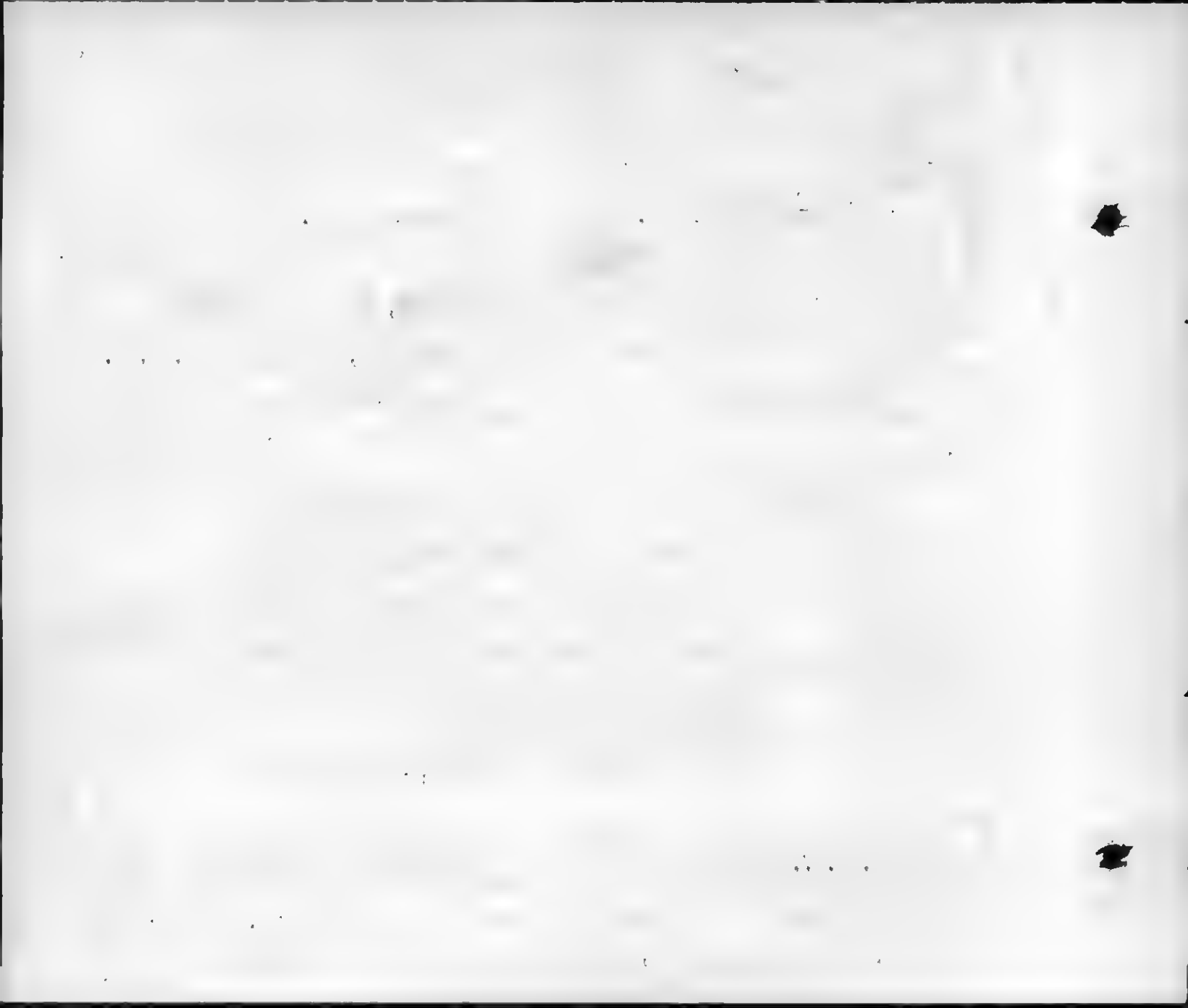
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL—WARWICK AND MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TERRY Middle Alan Last LEWIS				4. DATE OF DEATH Month JUNE Day 8 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 18, 1953	
9. AGE (In years last birthday) 1 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME CARLTON LEWIS				14. MOTHER'S MAIDEN NAME DOROTHY JEAN BRINKMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pleural Fistula 470X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) R. Lobar Pneumonia (Streptococcus) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 8 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-2-58 to 6-8-58 , that I last saw the deceased alive on 6-8-58 , and that death occurred at 5:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. W. Eliason M.D.				ADDRESS (Street, city or town, state) Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. H. W. ELIASON				DATE SIGNED 6/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6348

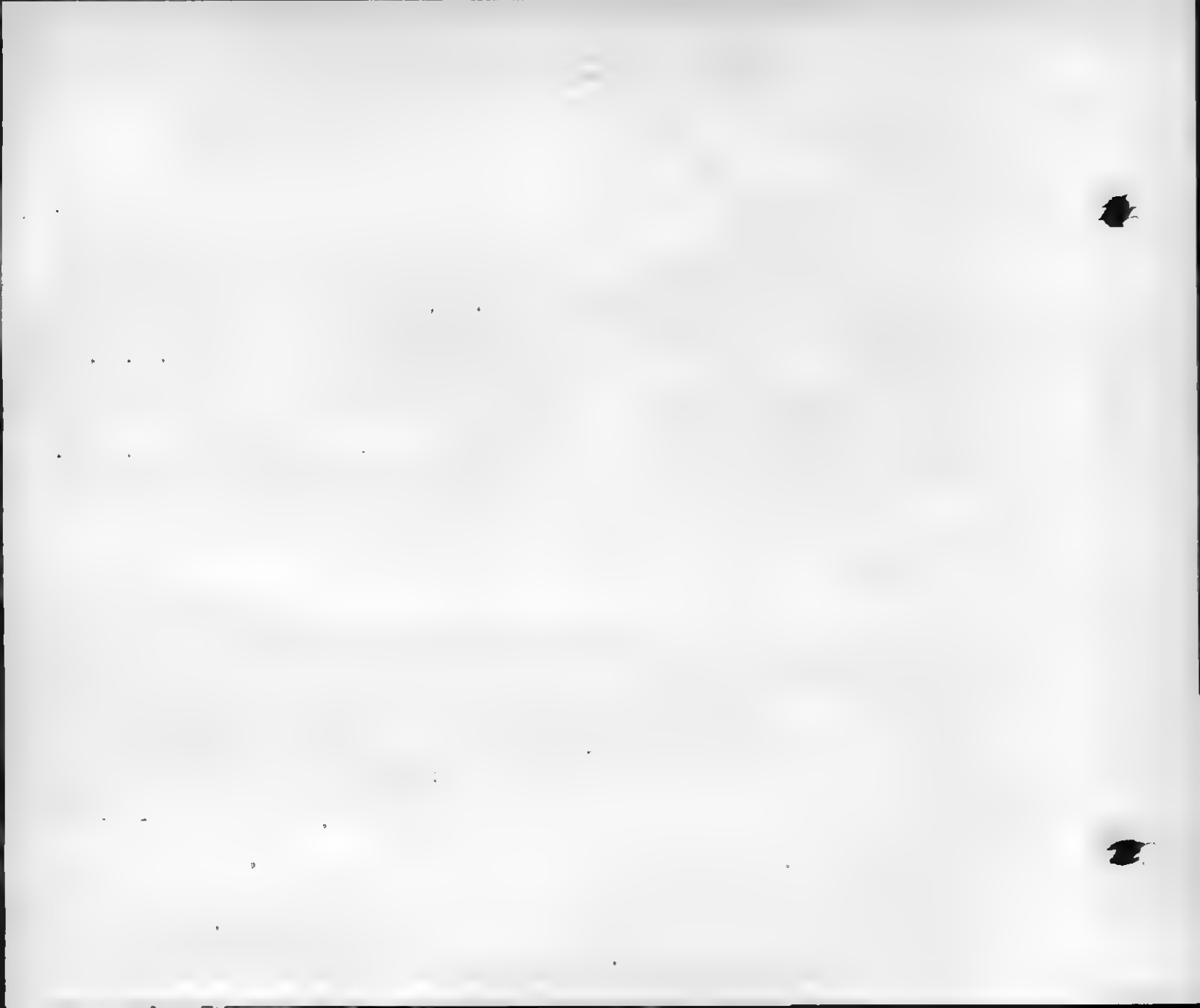
CERTIFICATE OF DEATH

Reg. Dist. No. **06353**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 327 City View Terrace		d. STREET ADDRESS 327 City View Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Allard Lowery		4. DATE OF DEATH Month Day Year June 22, 1958 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1880
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Machinist helper		10b. KIND OF BUSINESS OR INDUSTRY Silk	
11. BIRTHPLACE (State or foreign country) MARYLAND Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Thomas Lowery		14. MOTHER'S MAIDEN NAME Elizabeth Kirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 705-07-9640	
17. INFORMANT Mrs Jessie Lowery, 327 City View Terr. Cumb.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 - 22, 19 58 to 6 - 22, 19 58 that I last saw the deceased alive on 6 - 22, 19 58 , and that death occurred at 3:00 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 6-23-58			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin		M.D. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF June 25, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24. REC'D BY REGISTRAR DATE JUN 25 '58	
		25. REGISTRAR'S SIGNATURE W. E. Smith	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6380

CERTIFICATE OF DEATH

Reg. Dist. No.

06354

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Frostburg d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS c/o Gunter Hotel E. Main, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last MANN		4. DATE OF DEATH Month 6 Day 8 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1878
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 58 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watch Repairman		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Piney Grove, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Millard Filmore Mann		14. MOTHER'S MAIDEN NAME Elizabeth Virginia Creek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Donald McNeil, 29 Bank St., Carnegie, Pa.		18. ADDRESS (Grandson)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 422.2 DUE TO Chr myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 s. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1958 to June 8, 1958 , that I last saw the deceased alive on June 8, 1958 , and that death occurred at 12:00 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE WOMcLane M.D.		ADDRESS (Street, city or town, state) Frostburg DATE SIGNED June 10 1958	
PHYSICIAN'S NAME (Type) WOMcLane MD		MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/10/58	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rudolph H. Winters		24a. REC'D BY REGISTRAR JUN 13 '58 24b. REGISTRAR'S SIGNATURE W. L. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6381

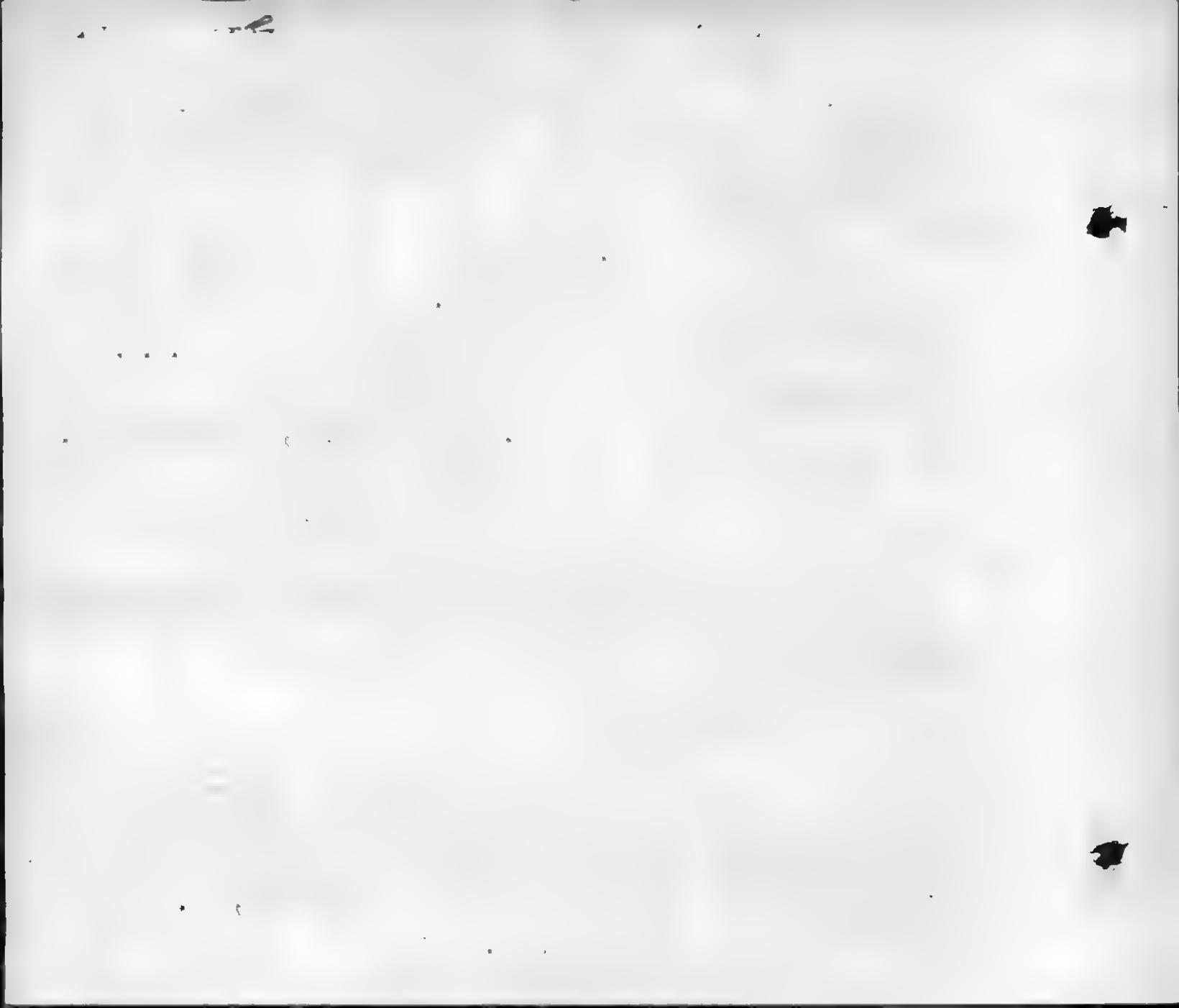
Item 14 Filed 6/27/58 at

CERTIFICATE OF DEATH

06355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS State Street			
3. NAME OF DECEASED (Type or print) First AGNES Middle A. Last McCONNELL				4. DATE OF DEATH Month 6 Day 24 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8th. 1894	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 6 Days 15 Hours 19 Min	IF UNDER 24 HRS Months 6 Days 15 Hours 19 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work Own Home				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME JAMES ALLERDICE				14. MOTHER'S MAIDEN NAME Jamima Allerdice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. LENARD WOYNICZ, LONACONING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 10 days - Years -						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 30, 1950 to June 24, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 315 ROADWAY DATE SIGNED John B. Davis, M.D.							
ACTUAL SIGNATURE John B. Davis, M.D.							
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/1958		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE JUN 30 '58	
				24b. REGISTRAR'S SIGNATURE George Eichhorn			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

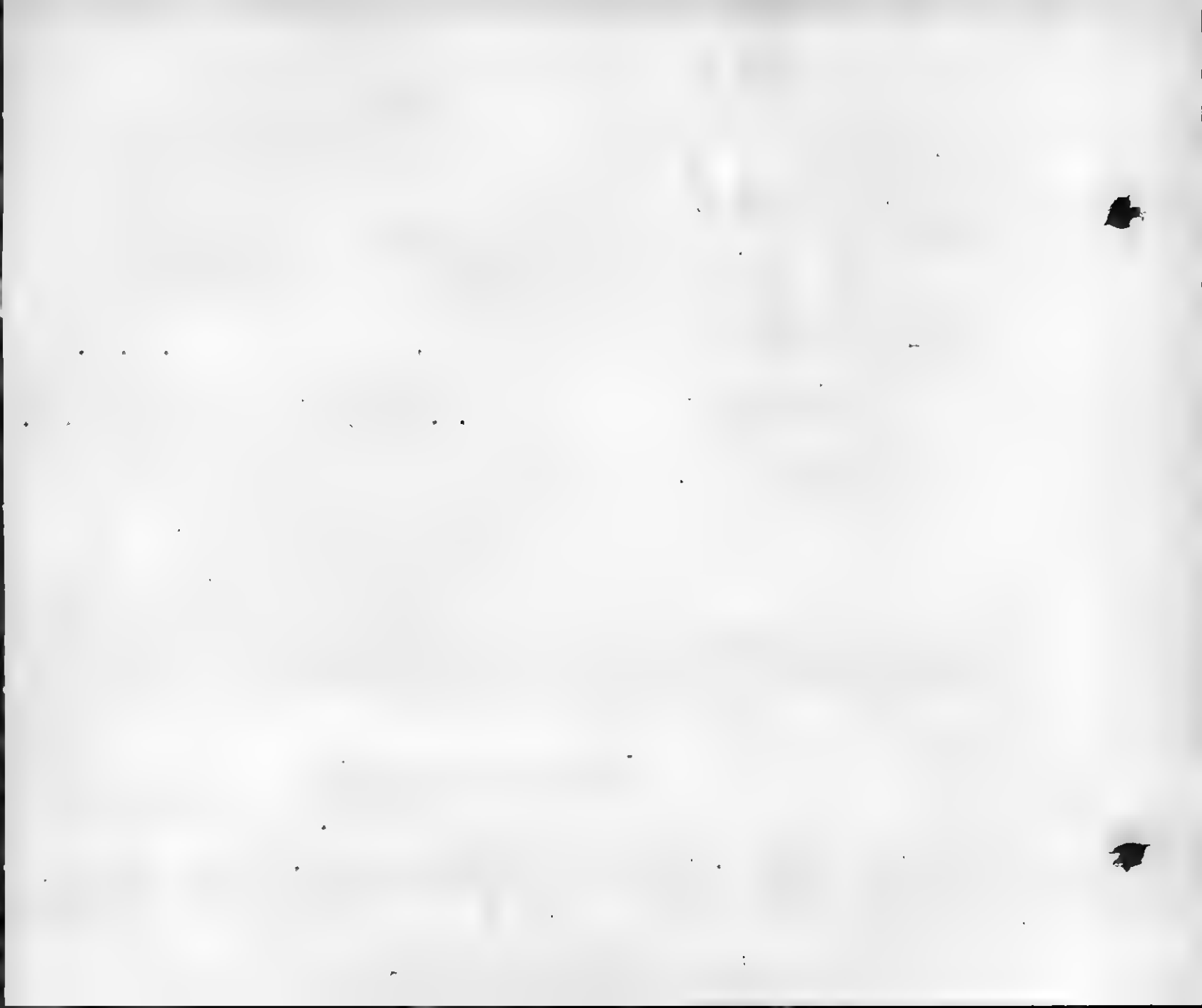
6349

CERTIFICATE OF DEATH

Reg. Dist. No. 06356

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4/30/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
3. NAME OF DECEASED (Type or print) First James Middle McCormick Last McCormick		4. DATE OF DEATH Month June Day 15 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1873
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Coal Mining		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph McCormick		14. MOTHER'S MAIDEN NAME Jane Matheison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. Allegany County Infirmary Records	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 31 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) Chronic angina pectoris		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis of lower legs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/30/58 , 19, to 6/15/58 , 19, that I last saw the deceased alive on 6/14/58 , 19, and that death occurred at 11:00PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 6/16/58			
ACTUAL SIGNATURE James E. McLean, M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/58	
22c. NAME OF CEMETERY OR CREMATORY St. Paul - Western Hill		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Bova - Western Hill, Md.		24a. REC'D BY REGISTRAR JUN 20 '58	
		24b. REGISTRAR'S SIGNATURE Carla	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06357

Reg. Dist. No.

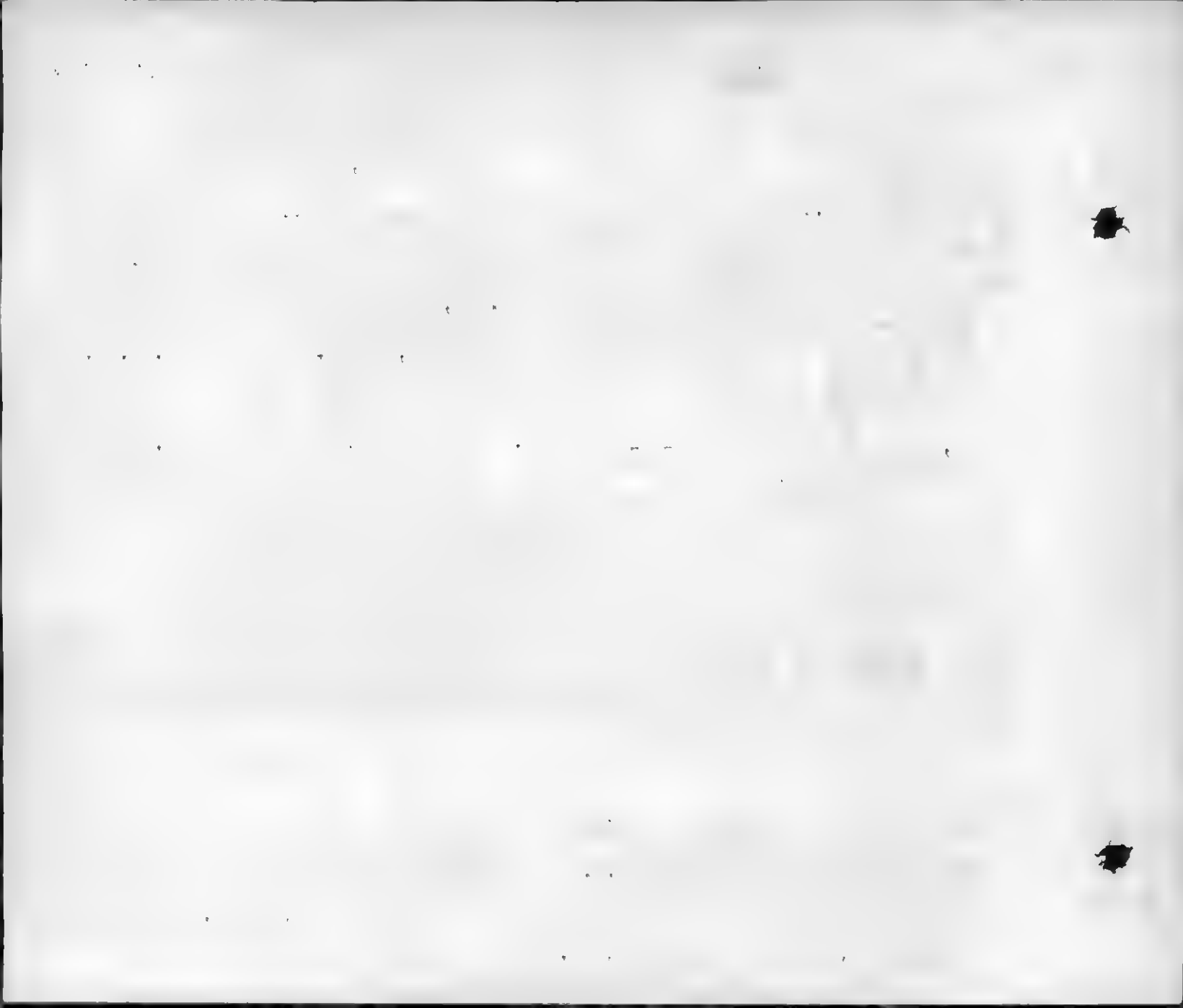
Items 8 & 9 Film 6350 7/18/58 STE

6350

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 222 Schley St.,		d. STREET ADDRESS 109 Frederick St.,	
3. NAME OF DECEASED (Type or print) First CHARLIE Middle McFARLAND Last McFARLAND		4. DATE OF DEATH Month June Day 24 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880 Dec. 21, 1879 9. AGE (In years last birthday) 77 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	11. BIRTHPLACE (State or foreign country) Everett, Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Andrew McFarland	
14. MOTHER'S MAIDEN NAME Elizabeth Leader		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO 211-18-1104		17. INFORMANT Mrs. Roy McFarland Address Everett, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c) stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 24, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/27/58	22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery	22d. LOCATION (City, town, or county) (State) Everett, Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
24b. REGISTRAR'S SIGNATURE W. Leach			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06358**

6396

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence, Cresaptown		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Mary McKee		4. DATE OF DEATH June 10 19 58	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James Cullen		14. MOTHER'S MAIDEN NAME Mary MCKENZIE Mckenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Helen Durr, Cresaptown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 420.1 DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus 6 years			INTERVAL BETWEEN ONSET OF DEATH 9 days 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 - 6 , 19 58 , to 6 - 10 , 19 58 , that I last saw the deceased alive on 6 - 10 , 19 58 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 6-11-58	
PHYSICIAN'S NAME (Type) Ralph W. Ballin M.D. 62 Greene Street, Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 12, 1958	22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR JUN 13 '58	24b. REGISTRAR'S SIGNATURE Al. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6351

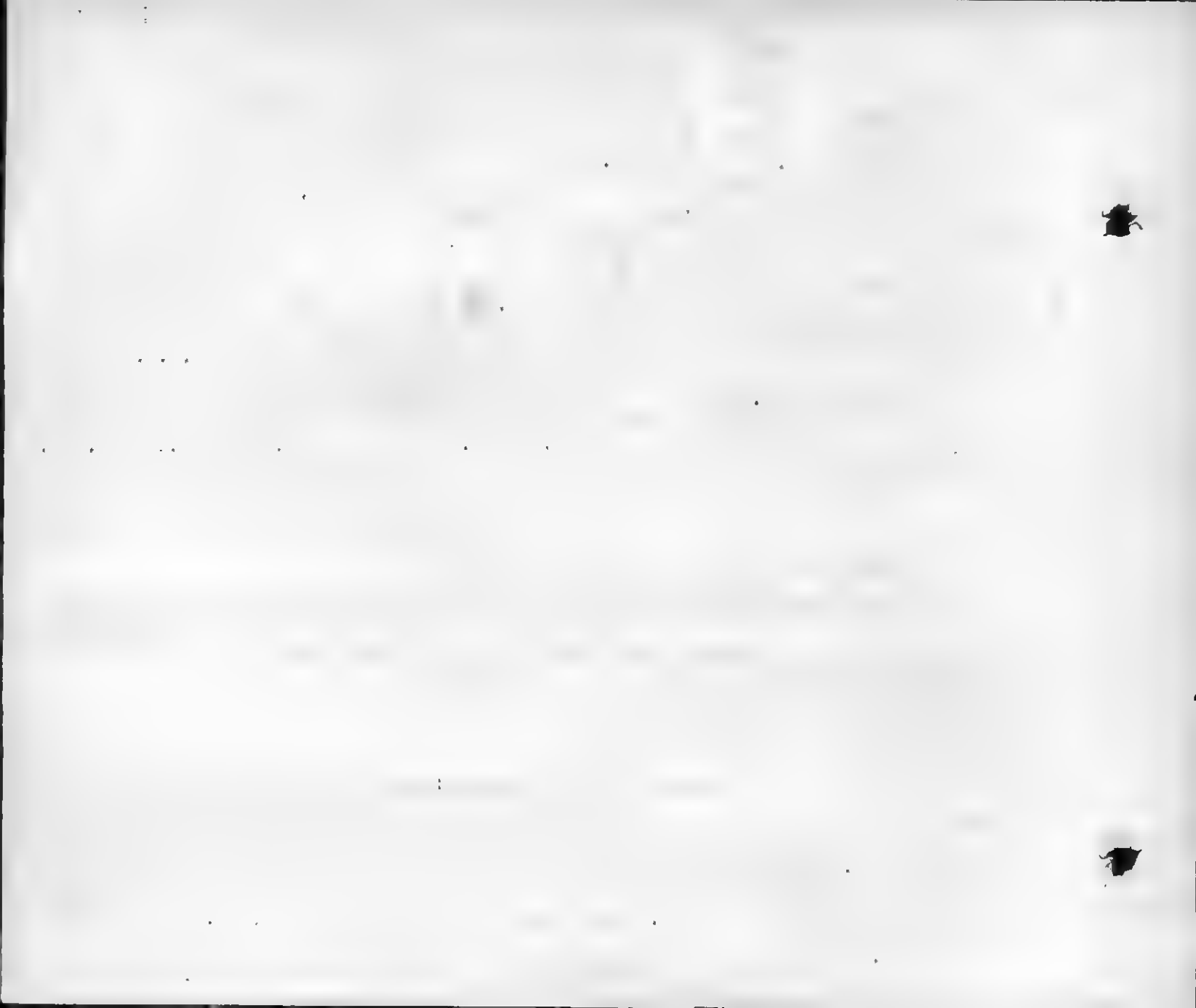
CERTIFICATE OF DEATH

06359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 1 1/2 HRS.		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 111 WEST MARY ST., XXXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CLARA Genevieve		First CLARA		Middle Genevieve		Last MERRITT		4. DATE OF DEATH Month JUNE		Day 12		Year 19 58							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 24, 1908		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49		IF UNDER 24 HRS Days 49		Hours 49					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland,				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME FREDERICK H. BEAR						14. MOTHER'S MAIDEN NAME KATHERINE Woerner?													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No,				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Roy L. Merritt 111 W. Mary St., Cumb. Md.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X Metastatic Carcinoma - Pulmonary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Rectum DUE TO (c) 6 years														INTERVAL BETWEEN ONSET AND DEATH 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/11/58 to 12/12/58 , that I last saw the deceased alive on 10 June 1958 , and that death occurred at 9:23 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED JAMES B. STEGMAIER MD 122 So Centre St, Cumberland 12 June 58																			
ACTUAL SIGNATURE JAMES B. STEGMAIER				PHYSICIAN'S NAME (Type) J. STEGMAIER															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/14/58				22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery				22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George								ADDRESS Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE JUN 16 '58				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

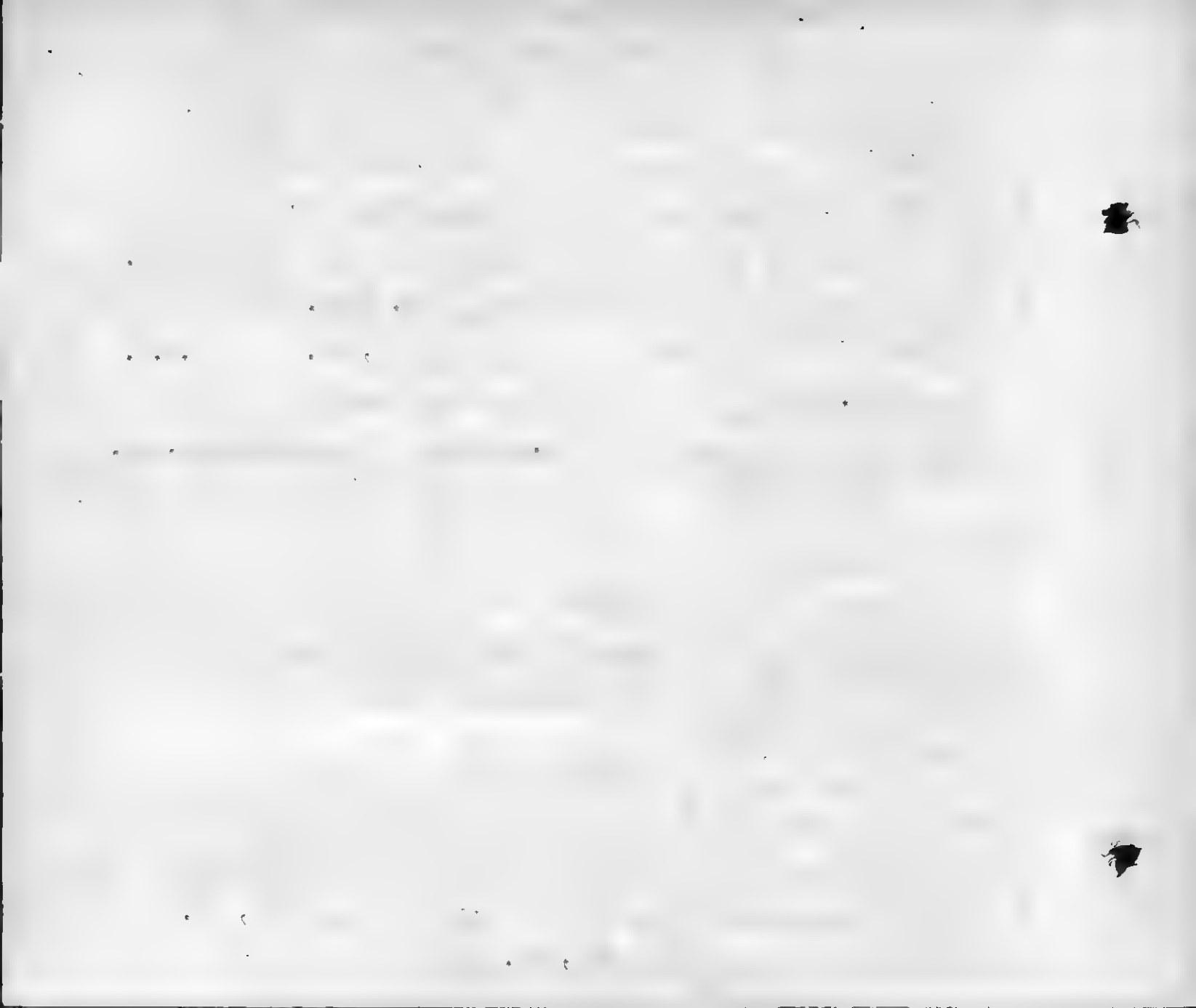
06360

6397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charlestown Street		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle METZ Last METZ		4. DATE OF DEATH Month June Day 25th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20th, 1880, 78^{yr}
9. AGE (In years last birthday) 78^{yr}		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner Coal Mine		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Metz		14. MOTHER'S MAIDEN NAME Rebecca Lease	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Raymond Metz, Lonaconing, MD.	
17. INFORMANT Mr. Raymond Metz, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident (SON) DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) 2 days (c) years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1958 to June 25, 1958 , that I last saw the deceased alive on June 25, 1958 , and that death occurred at 1 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		ADDRESS (Street, city or town, state) MAIN ST LONACONING MD.	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. M.D.		DATE SIGNED 6-27-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONACONING, MD.	
24a. REC'D BY REGISTRAR DATE 6-28-58		24b. REGISTRAR'S SIGNATURE Qu...	



6382

CERTIFICATE OF DEATH

Reg. Dist. No.

06361

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>8 Wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>E.</u> Last <u>MICHAELS</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1875</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Savage</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Peter Rarick</u>		14. MOTHER'S MAIDEN NAME <u>Emma Lou Lafferty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. John Davis, Box 54, Eckhart, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5, 1958</u> , to <u>June 2, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>6:15 P.</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>W. H. McFarlane</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>June 4, 1958</u>	
PHYSICIAN'S NAME (Type) <u>W. H. McFarlane</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery Frostburg</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Winters</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u>	
ADDRESS <u>23 E. Main, Frostburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

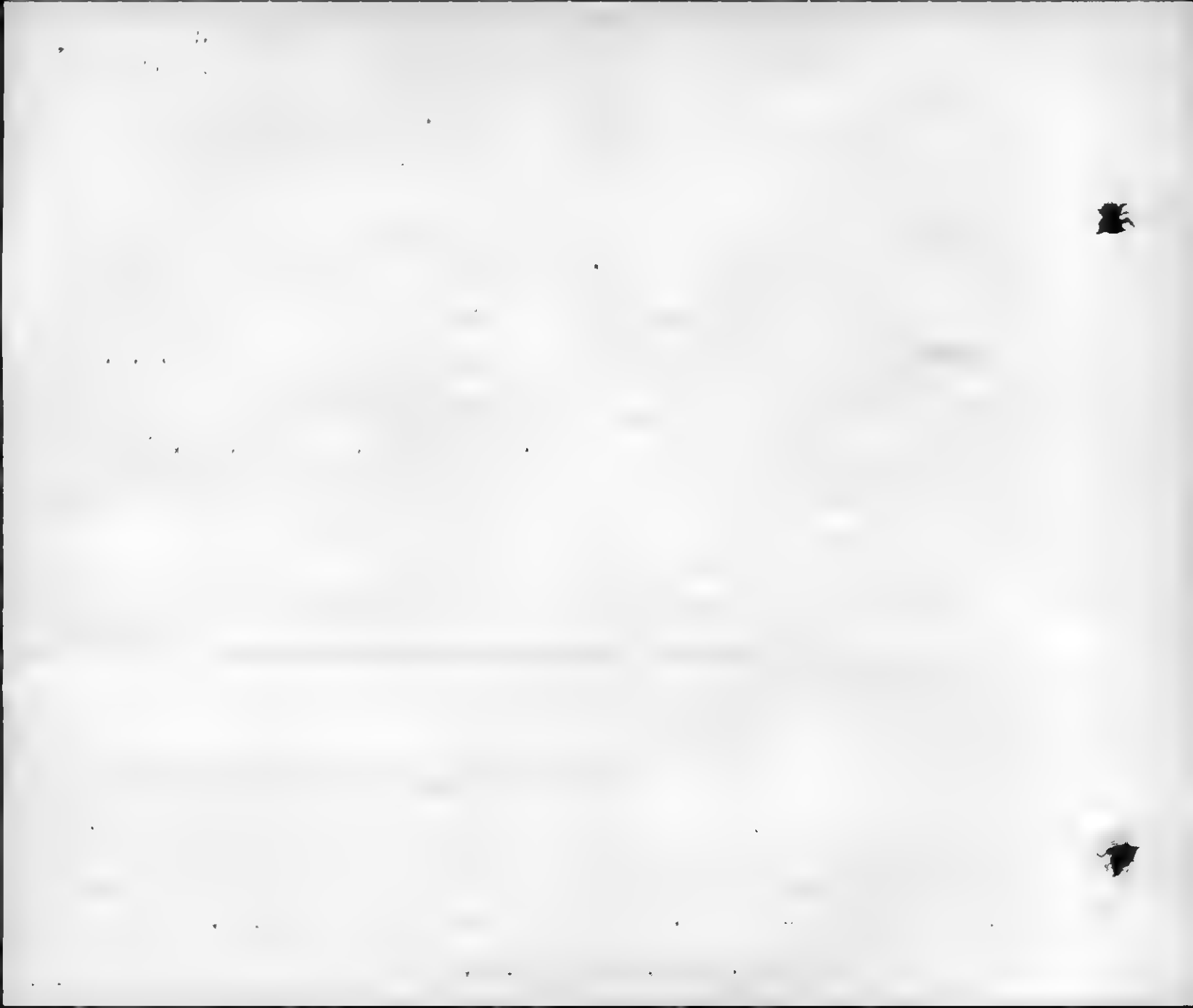
6398

CERTIFICATE OF DEATH

Reg. Dist. No. 06362

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last MICHAELS		4. DATE OF DEATH Month 6 Day 13 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-1869
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Harmon Michaels		14. MOTHER'S MAIDEN NAME Catherine Herman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Mrs. John Davis, Eckhart, Md. (Daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatitis 580x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 3, 1958 to June 13, 1958 , that I last saw the deceased alive on June 11, 1958 and that death occurred at 9:20 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED 6-14-58 ACTUAL SIGNATURE WOM Lane M.D. Frostburg PHYSICIAN'S NAME (Type) WOM Lane Md J			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-16-58	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home Richard H. Hafer		24a. REC'D BY REGISTRAR JUN 20 '58 24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eckhart Flat		d. STREET ADDRESS 48 Grant St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last MILLER		4. DATE OF DEATH Month June Day 8 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY Pajama factory	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Elrick		14. MOTHER'S MAIDEN NAME Isabell Sturtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212-01-9798	
17. INFORMANT Mrs. Marguerite Glotfelty, Frostburg, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days - 5 yrs -			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1953 to June 8, 1958 , that I last saw the deceased alive on June 7, 1958 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Broadway, Frostburg, Md. DATE SIGNED 6/9/58			
ACTUAL SIGNATURE John B. Davis, M.D.			
PHYSICIAN'S NAME (Type) John B. Davis, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-1958	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JUN 12 '58	
		24b. REGISTRAR'S SIGNATURE Albrecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

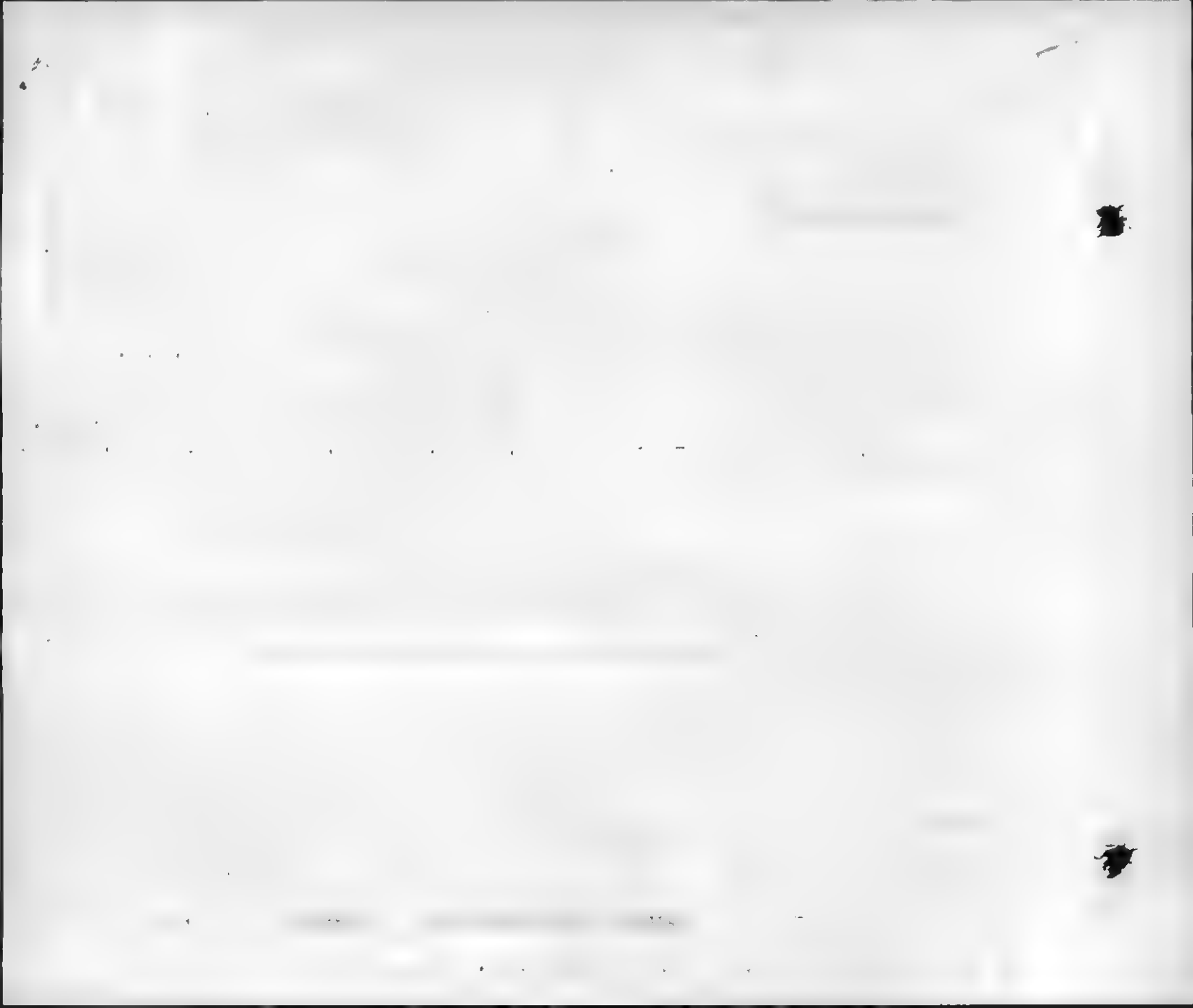
6384

CERTIFICATE OF DEATH

06364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 318 EAST MAIN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle LOWERY Last MINNICKS				4. DATE OF DEATH Month 6 Day 15 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-1907		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Manager		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (State or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Edward Minnicks				14. MOTHER'S MAIDEN NAME Adeline Lowery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. War II 214-07-4418		17. INFORMANT Mrs. Katherine G. Minnicks		Address Frostburg, Md. 318 E. Main,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Arteriosclerosis complicated by myocardial infarction</i> DUE TO (b) <i>Coronary Artery Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour _____ o. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		20g. (County) _____		20h. (State) _____		20i. (City or town) _____	
21. I certify that I attended the deceased from <i>April 1954</i> to <i>June 15, 1958</i> , that I last saw the deceased alive on <i>June 11, 1958</i> , and that death occurred at <i>1:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>Martin M. Rothstein</i> M.D. <i>48 BARBARA</i> PHYSICIAN'S NAME (Type) <i>MARTIN M. ROTHSTEIN M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 6-18-58		22c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		22d. LOCATION (City, town or county) (State) ECKHART, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul H. Mortimer</i>				23b. ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR JUN 20 1958	
24b. REGISTRAR'S SIGNATURE <i>Archie</i>							



06365

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1

the funeral director, the funeral director, should be filled with

VS A15 (4)
15M 30/57

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/25/54	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Mitchell Last Mitchell		4. DATE OF DEATH Month June Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1895
9. AGE (In years last birthday) 63 yrs		10. IF UNDER 1 YEAR Months 4 Days 12 Hours 15 Min.	11. IF UNDER 24 HRS Months 4 Days 12 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Restraunt Business		10b. KIND OF BUSINESS OR INDUSTRY (Asia Minor) Turkey	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Earnest Mitchell		14. MOTHER'S MAIDEN NAME Sylvia Alexoudi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. P. O. BOX 599	
17. INFORMANT ALLEGANY COUNTY INFIRMARY RECORDS		18. ADDRESS Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 5 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1954 , to June 12, 1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 4:52 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene Street	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-58	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 16 '58		24b. REGISTRAR'S SIGNATURE Paul	



6353

CERTIFICATE OF DEATH

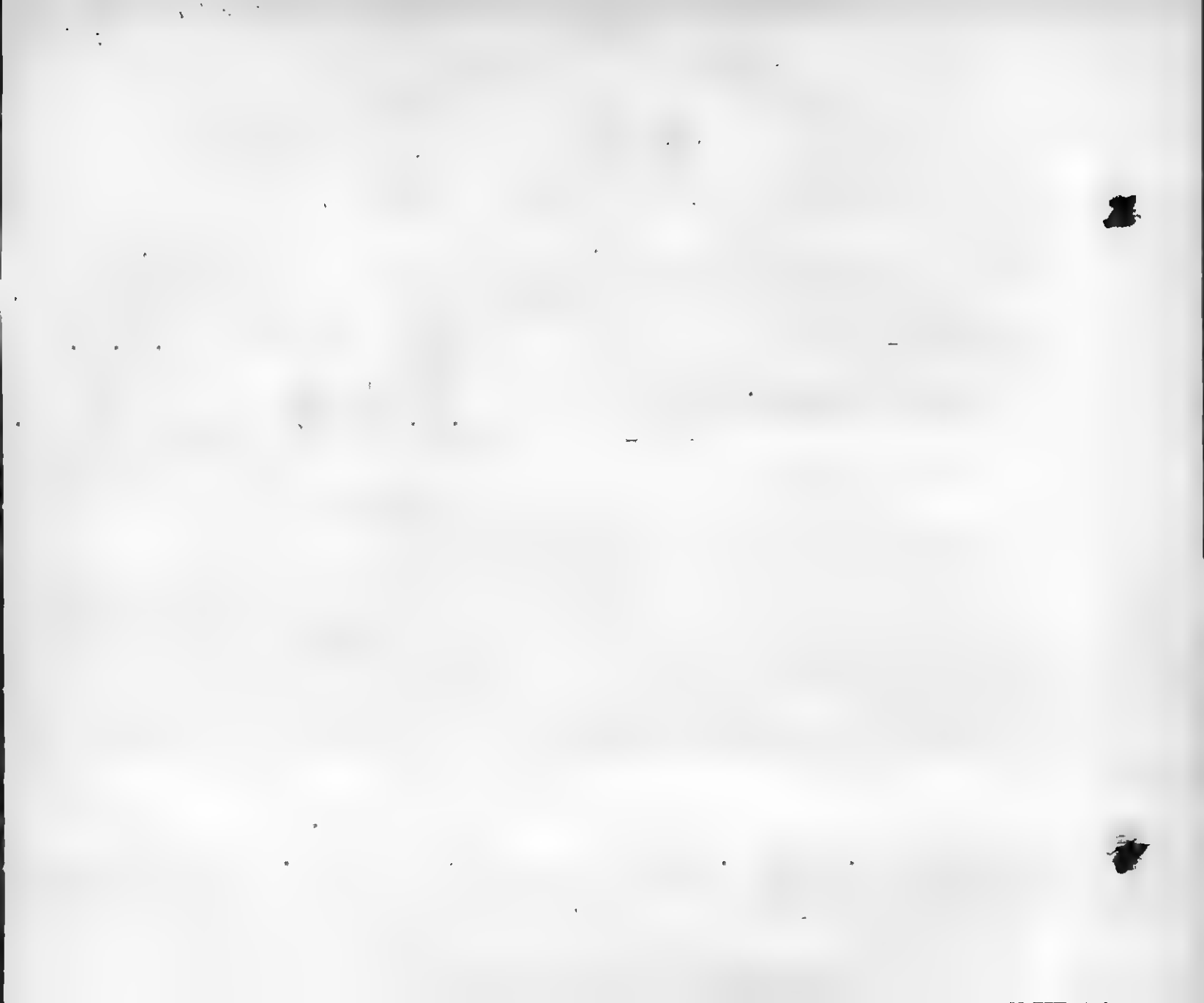
Reg. Dist. No.

06366

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 6 Welsh Street	
3. NAME OF DECEASED (Type or print) First Martin Middle A. Last Nolan		4. DATE OF DEATH Month June Day 20 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael B. Nolan		14. MOTHER'S MAIDEN NAME Annie O'Riley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-0596597	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422. DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) Chronic Valvular Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Proximal atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/28/58 , 19____, to 6/20/58 , 19____, that I last saw the deceased alive on 6/19/58 , 19____, and that death occurred at 1:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 6/20/58			
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-1958	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR JUN 23 '58 24b. REGISTRAR'S SIGNATURE W. H. Smith	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6354

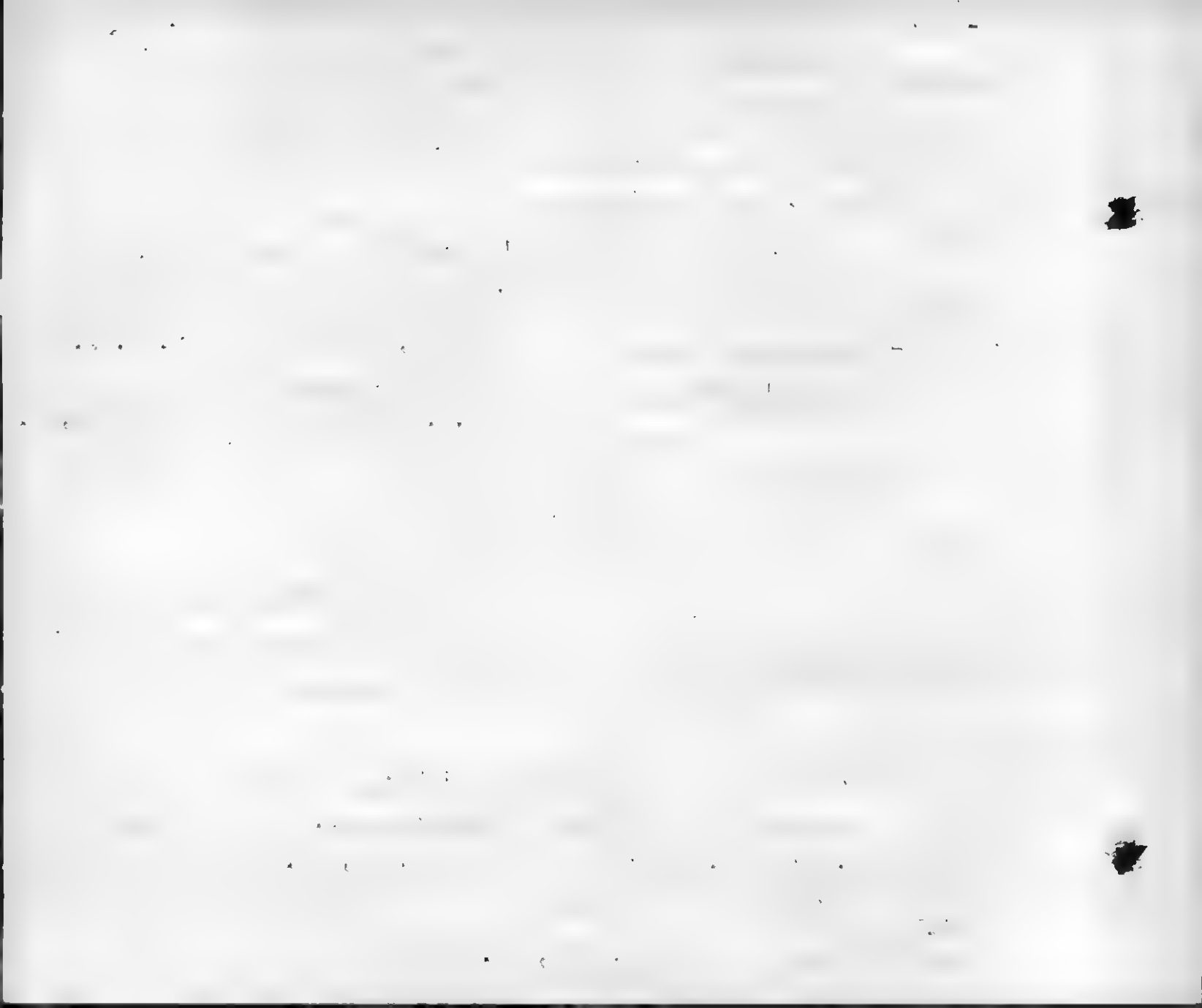
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/6/55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last O'Rourke		4. DATE OF DEATH Month June Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 25 Days 25 Hours 25 Min 25	IF UNDER 74 HRS Months 25 Days 25 Hours 25 Min 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick O'Rourke		14. MOTHER'S MAIDEN NAME Mary Ann Caven	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Cerebral arteriosclerosis DUE TO Chronic Nephritis DUE TO Severe Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Atherosclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 6/6/55 , 19 55 , to 6/1/58 , 19 58 , that I last saw the deceased alive on 5/31/58 , 19 58 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 6/2/58	
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/58	
22c. NAME OF CEMETERY OR CREMATORY St Michaels		22d. LOCATION (City, town, or county) (State) Frostburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE George Eickhorn ADDRESS Lenaeoning, Md.		24a. REC'D BY REGISTRAR JUN 4 '58 24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6355

CERTIFICATE OF DEATH

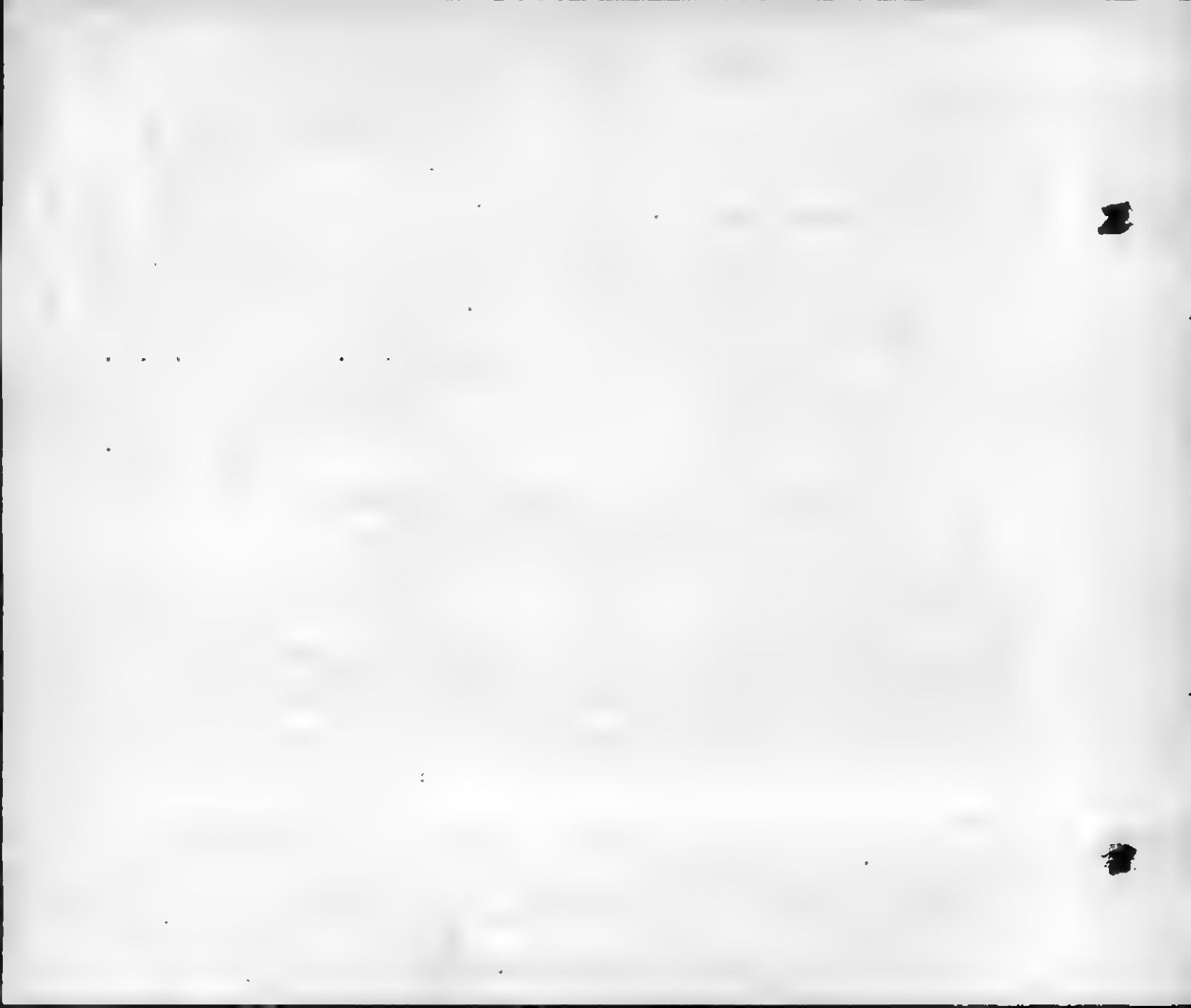
Reg. Dist. No.

06368

1. PLACE OF DEATH COUNTY ALLEGANY M		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.		e. STREET ADDRESS 444 SEYMOUR STREET	
3. NAME OF DECEASED (Type or print) First CARLTON Middle RANDALL Last POLAN		4. DATE OF DEATH Month JUNE Day 7 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 27, 1957
9. AGE (In years last birthday) yrs 8		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CARLTON POLAN		14. MOTHER'S MAIDEN NAME NORMA BALLOU	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - Pulmonary			INTERVAL BETWEEN ONSET AND DEATH 1 day 8 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 57 , to June , 19 58 , that I last saw the deceased alive on June 7 , 19 58 , and that death occurred at 2:40 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md DATE SIGNED 6/8/58			
ACTUAL SIGNATURE Dr. Overton Himmelwright		PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-9-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE W. J. Seach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6385

CERTIFICATE OF DEATH

Reg. Dist. No. 06369

1. PLACE OF DEATH a. COUNTY NORTH* Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md/ b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 Depot Terrace				e. STREET ADDRESS 49 Depot Terrace			
3. NAME OF DECEASED (Type or print) First Nellie Middle Pollock Last Pollock				4. DATE OF DEATH Month June Day 17 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1872		9. AGE (in years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris				14. MOTHER'S MAIDEN NAME Sorlitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 0		17. INFORMANT John Pollock Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Heart disease DUE TO C failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 14, 19 58 to June 17, 19 58 that I last saw the deceased alive on June 14, 19 58 and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED John B. Davis, MD							
ACTUAL SIGNATURE John B. Davis, MD							
PHYSICIAN'S NAME (Type) John B. Davis, MD Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/58		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Boul				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 06370

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(rural) Rt. 5, Cumberland, 1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Ashby,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Md.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Susan Pownell</u>		4. DATE OF DEATH Month Day Year <u>June 11, 19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Cedar Cliff, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Emily Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mary Wagoner</u>		Address <u>Fort Ashby W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apoplectic stroke</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-3-1953</u> to <u>6-11-1958</u> , that I last saw the deceased alive on <u>6-5-1958</u> , and that death occurred at <u>3:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Brings</u>		ADDRESS (Street, city or town, state) <u>57 Green Street</u>	
PHYSICIAN'S NAME (Type) <u>LEWIS BRINGS</u>		DATE SIGNED <u>6-16-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>6-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Ashby Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Ashby, Mineral, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Meryl S. Counts</u>		ADDRESS <u>Romney, W. Va.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06371

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

6400

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Route 4, Cumberland</u> 26 years c. LENGTH OF STAY IN 1b <u>Route 4, Cumberland</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Christie Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Route 4, Cumberland</u> d. STREET ADDRESS <u>Christie Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLETUS ELLSWORTH PRICE</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Male</u> <u>White</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>June 15, 19 58</u> 9. AGE (In years last birthday) <u>45</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Amer. Legion Post</u> 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William L. Price</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Gibbs</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW2 & Korean</u> 16. SOCIAL SECURITY NO. <u>214 05 5413</u> 17. INFORMANT <u>Mary M. Price</u> Address <u>Route 4, Cumberland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 17, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>June 18, 1958</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u> 22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight, Cumberland, Md.</u> 24a. REC'D BY REGISTRAR DATE <u>JUN 18 58</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06372

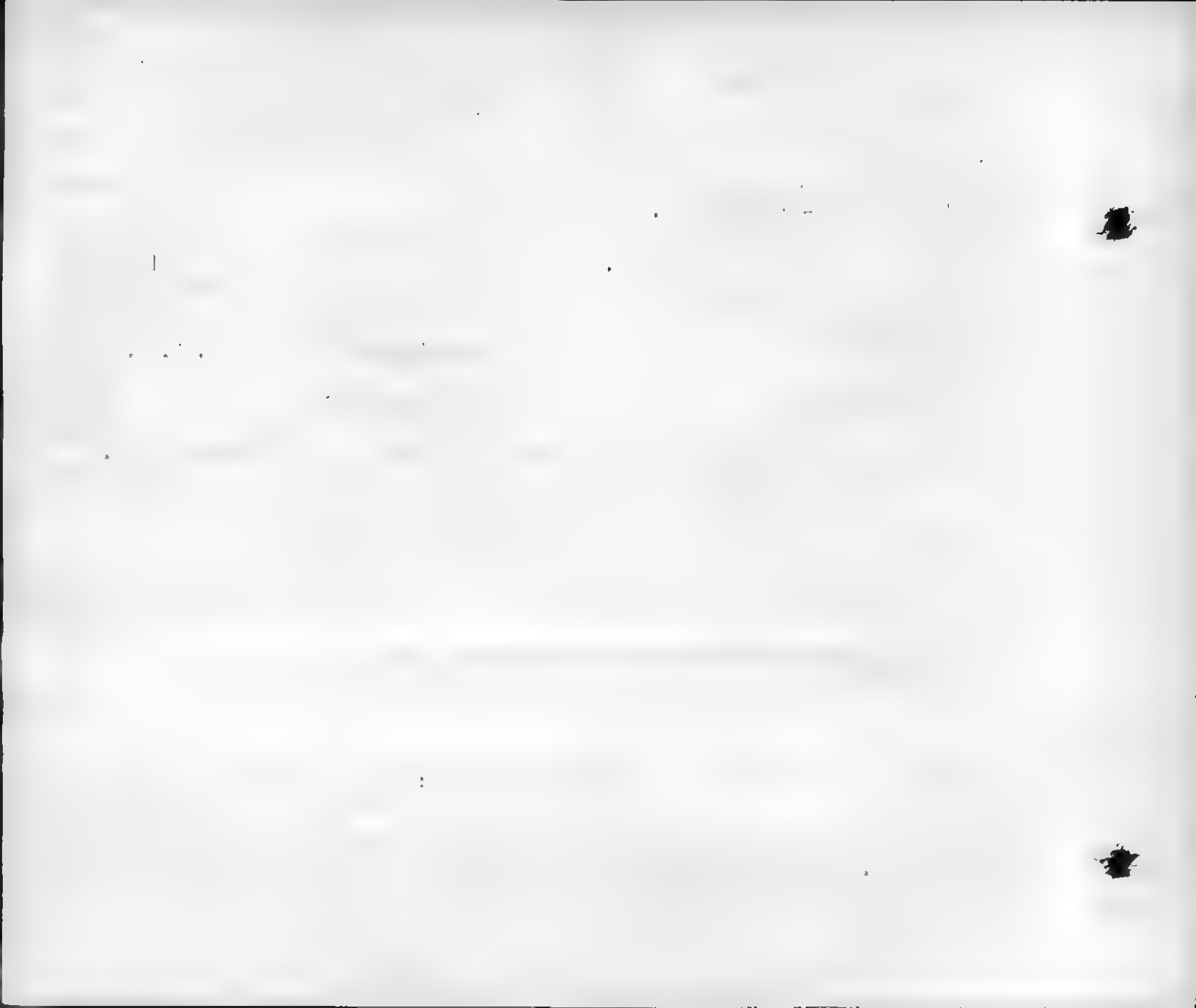
6356

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 64 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE WEST VIRGINIA b. COUNTY FORT ASHBY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give name of institution) MEMORIAL HOSPITAL-MEMORIAL AVE.		d. STREET ADDRESS							
3. NAME OF DECEASED (Type or print) First ALICE Middle M. Last PYLES		4. DATE OF DEATH Month JUNE Day 16 Year 1958							
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 15, 1889	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 16	Hours 10	Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md.,		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME BENJAMIN CORBIN		14. MOTHER'S MAIDEN NAME LAVERNIA URICE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from May , 19 58 , to June , 19 58 , that I last saw the deceased alive on June 6 , 19 58 , and that death occurred at 10:17 PM , from the causes and on the date stated above		ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md		DATE SIGNED 6/15/58					
ACTUAL SIGNATURE DR. OVERTON HIMMELWRIGHT		M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-58		22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		22d. LOCATION (City, town, or county) _____ (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUN 23 '58		24b. REGISTRAR'S SIGNATURE Alb...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6386

CERTIFICATE OF DEATH

Reg. Dist. No.

06373

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Pennsylvania b. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsburgh 4,			
d. NAME OF HOSPITAL (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS 1461 Orator Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle LOUIS Last REIHMS		4. DATE OF DEATH Month 6 Day 2 Year 19 58.					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1901	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Supt.		10b. KIND OF BUSINESS OR INDUSTRY Maintenance Supervisor		11. BIRTHPLACE (State or foreign country) Pittsburgh		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Reihms				14. MOTHER'S MAIDEN NAME Anna Clousen Pa.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 168-03-2291		17. INFORMANT Mrs. Clara Reihms, 1461 Orator St.,		Address Pittsburgh 4,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-31 , 19 58 to 6-2 , 19 58 , that I last saw the deceased alive on 6-2 , 19 58 , and that death occurred at 11:15 AM , from the causes and on the date stated above							
ACTUAL SIGNATURE H.C. Diehl M.D.				ADDRESS (Street, city or town, state) 39 W. Main St.		DATE SIGNED 6/2/58	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D., Frostburg, Ind.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-5-58		22c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial Park		22d. LOCATION (City, town, or county) (State) Allegheny County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE B.H. Wooten Home ADDRESS 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR JUN 6 '58		24b. REGISTRAR'S SIGNATURE Wooten	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6387

CERTIFICATE OF DEATH

06374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 4 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 38 Uhl Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORA Middle JANE Last REPHANN		4. DATE OF DEATH Month 6 Day 8 Year 19 58.	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1886
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months 11 Days 19 Hours 58 Min.	IF UNDER 24 HRS Months 11 Days 19 Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Coal City, Illinois.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert White	
14. MOTHER'S MAIDEN NAME Jane Nesbit		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Alfred Repham, 38 Uhl St., Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension with Sclerosis DUE TO Uterine Fibroid (c) 12 yrs.		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast - Complete mastectomy 9 yrs. ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-4 19 58 , to 6-8 19 58 , that I last saw the deceased alive on 6-8 19 58 , and that death occurred at 4 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl M.D.		ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED 6/9/58	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		FROSTBURG, MD.	
22a. SUP AL. CREMATION, BURIAL, or other (Specify) Burial		22b. DATE THEREOF 6/11/58	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR June 13 58	
24b. REGISTRAR'S SIGNATURE W. L. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06375

6357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 11 DAYS	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER	
3. NAME OF DECEASED (Type or print) First RICHARD Middle DALE Last RILEY		4. DATE OF DEATH Month JUNE Day 3 Year 19 58.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21, 1958.
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) KEYSER, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD O. RILEY		14. MOTHER'S MAIDEN NAME VIRGINIA JUDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulvic Abscess 756.2 DUE TO (b) Intestinal Perforation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Congenital Multiple Atraxia (Intestinal) DUE TO 11 days. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Heart Defect			INTERVAL BETWEEN ONSET AND DEATH 2 days 13 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 23 , 19 58 , to June 3 , 19 58 , that I last saw the deceased alive on June 3 , 19 58 , and that death occurred at 8:40 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED June 3, 58			
ACTUAL SIGNATURE W. B. Grove		PHYSICIAN'S NAME (Type) DR. XXXXXXXXXX D. B. GROVE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-5-58	22c. NAME OF CEMETERY OR CREMATORY Brown Point	22d. LOCATION (City, town, or county) (State) Keyser W. Va
23. FUNERAL DIRECTOR'S SIGNATURE Thomas R. Smith		24. REC'D BY REGISTRAR W. B. Grove	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

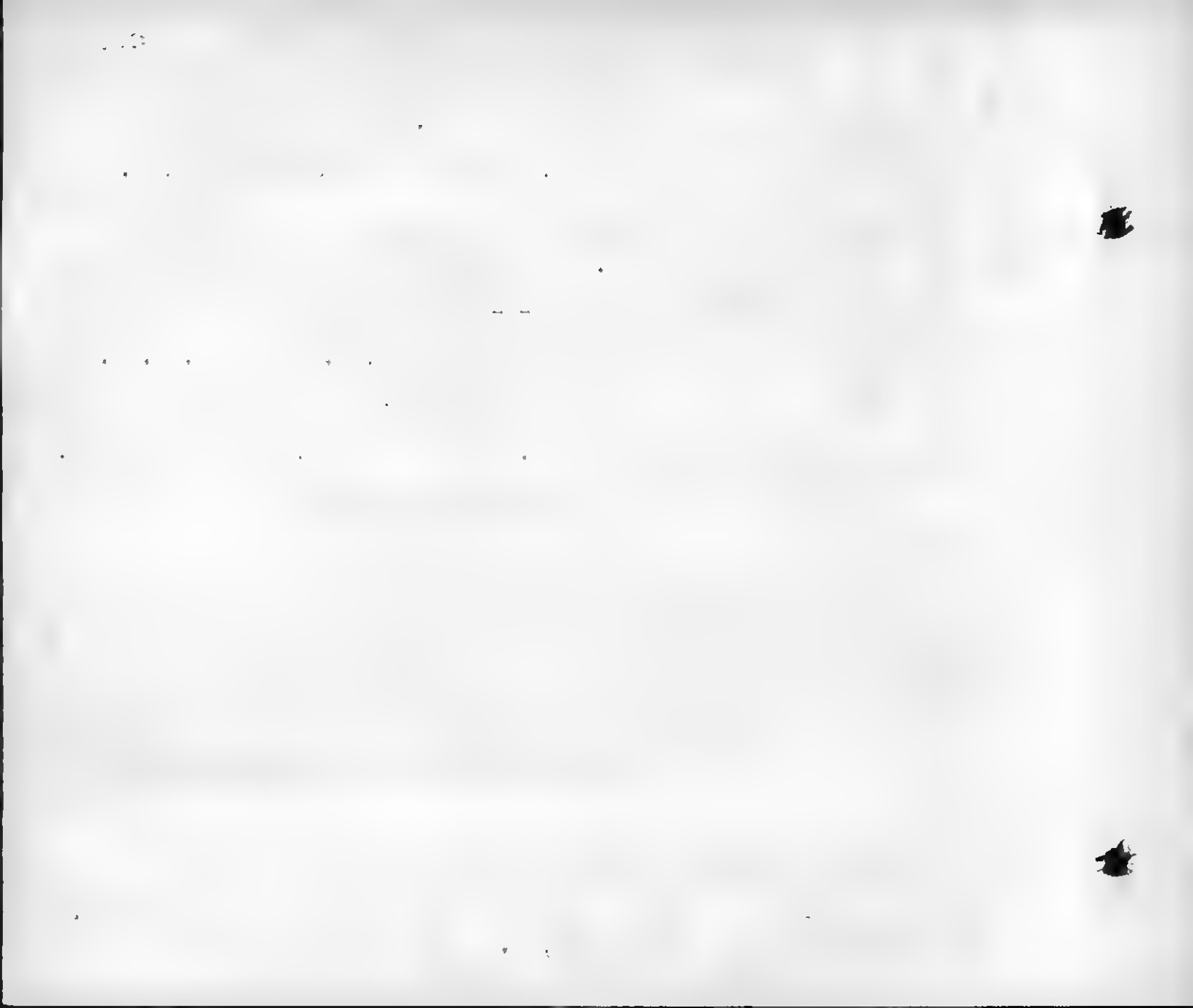
6388

CERTIFICATE OF DEATH

Reg. Dist. No.

06376

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 75 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart Mines, Frostburg, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle G. Last Rizer			4. DATE OF DEATH Month 6 Day 30 Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-3-1880		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor		10b. KIND OF BUSINESS OR INDUSTRY Brick Yard		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Simon Rizer			14. MOTHER'S MAIDEN NAME Henrietta Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-10-9883		17. INFORMANT Mrs. Timothy Thomas Eckhart Mines, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral arterial sclerosis DUE TO (c) Myocardial Dilatation							INTERVAL BETWEEN ONSET AND DEATH 23 hrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Dilatation (c) Pulmonary Edema.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/22 , 19 58 , to 6/30 , 19 58 , that I last saw the deceased alive on 6/30 , 19 58 , and that death occurred at 6:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 26 W. Mechanic St. Frostburg, Md. DATE SIGNED							
ACTUAL SIGNATURE Frank T. Harraut M.D.		PHYSICIAN'S NAME (Type) FRANK T. HARRAUT MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-1958		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Mattingly				24a. REC'D BY REGISTRAR JUL 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6389

CERTIFICATE OF DEATH

Reg. Dist. No.

06377

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 W. Main St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle C. Last ROBERTS		4. DATE OF DEATH Month JUNE Day 29 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1874
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	IF UNDER 24 HRS Months 83 Days 83 Hours 83 Min. 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mathias Rodde		14. MOTHER'S MAIDEN NAME Ann Hicks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Richard MacMannis, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Chr. Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Senility (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 week 3 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-22 , 19 58 , to 6-29 , 19 58 , that I last saw the deceased alive on 6-29 , 19 58 , and that death occurred at 7 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md. DATE SIGNED Jul 2 1958			
ACTUAL SIGNATURE H. C. Diehl		M.D. W. Main St., Frostburg, Md.	
PHYSICIAN'S NAME (Type) H. C. Diehl, M. D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-1958	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE Jul 2 1958		24b. REGISTRAR'S SIGNATURE Overland	



DR. ~~FAW~~ FAW

6358

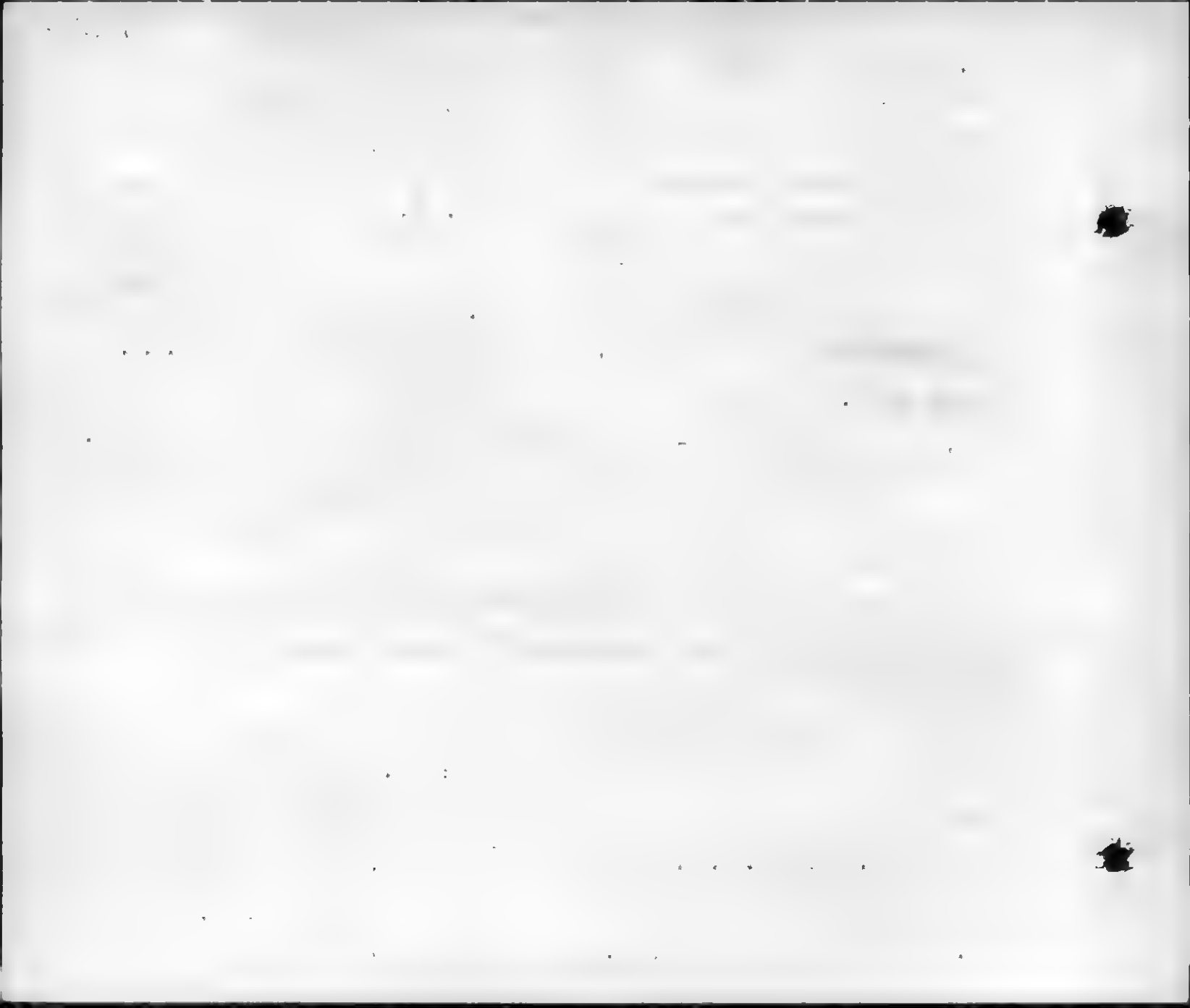
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 30 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle WILLIAM Last SEE		4. DATE OF DEATH Month JUNE Day 24 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 10 1897
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker		10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
11. BIRTHPLACE (State or foreign country) MARYLAND North Branch		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Nathaniel P. See		14. MOTHER'S MAIDEN NAME CORA STICKLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-2638	
17. INFORMANT MEMORIAL HOSPITAL, MEMORIAL & WARWICK STS.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 561.1 Uremia and toxic myocardial failure DUE TO (b) Intestinal obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Femoral hernia, left PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis and pyelonephrosis Right kidney hyp		INTERVAL BETWEEN ONSET AND DEATH 5 weeks 5 days 28 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30 , 19 58 , to June 24 , 19 58 , that I last saw the deceased alive on June 24 , 19 58 , and that death occurred at 4:09 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W. M. Fawcett		M.D. Cumberland Md June 24	
PHYSICIAN'S NAME (Type) DR. W. F. FAW			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 6/26/58	22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 26 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6359

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 20 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY	
3. NAME OF DECEASED (Type or print) First RACHEL Middle ANN Last SELF		4. DATE OF DEATH Month JUNE Day 21 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1882
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Lahamville		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEMIAN KEPLINGER		14. MOTHER'S MAIDEN NAME AMELIA DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma both lungs, probable original site lesion pyloric end of stomach DUE TO (b) a Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease, class 3		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 July 1957, to 21 June 1958, that I last saw the deceased alive on 20 June 1958, and that death occurred at 5:55 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 122 S. Centre St Cumberland, Md	
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		DATE SIGNED 21 June 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-58	
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		22d. LOCATION (City, town, or county) (State) Fort Ashby W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 24 1958		24b. REGISTRAR'S SIGNATURE W. A. Scarpelli	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

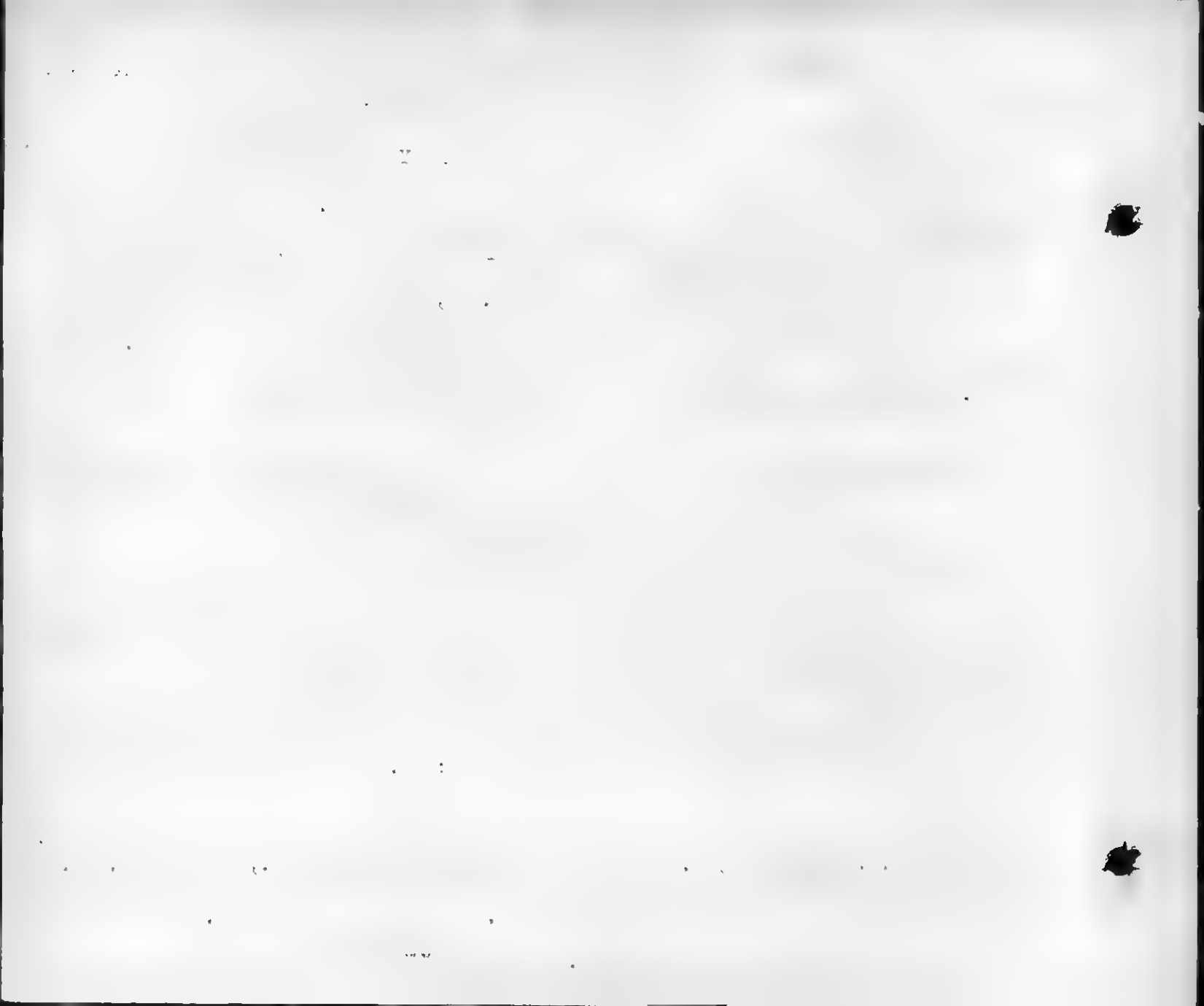
CERTIFICATE OF DEATH

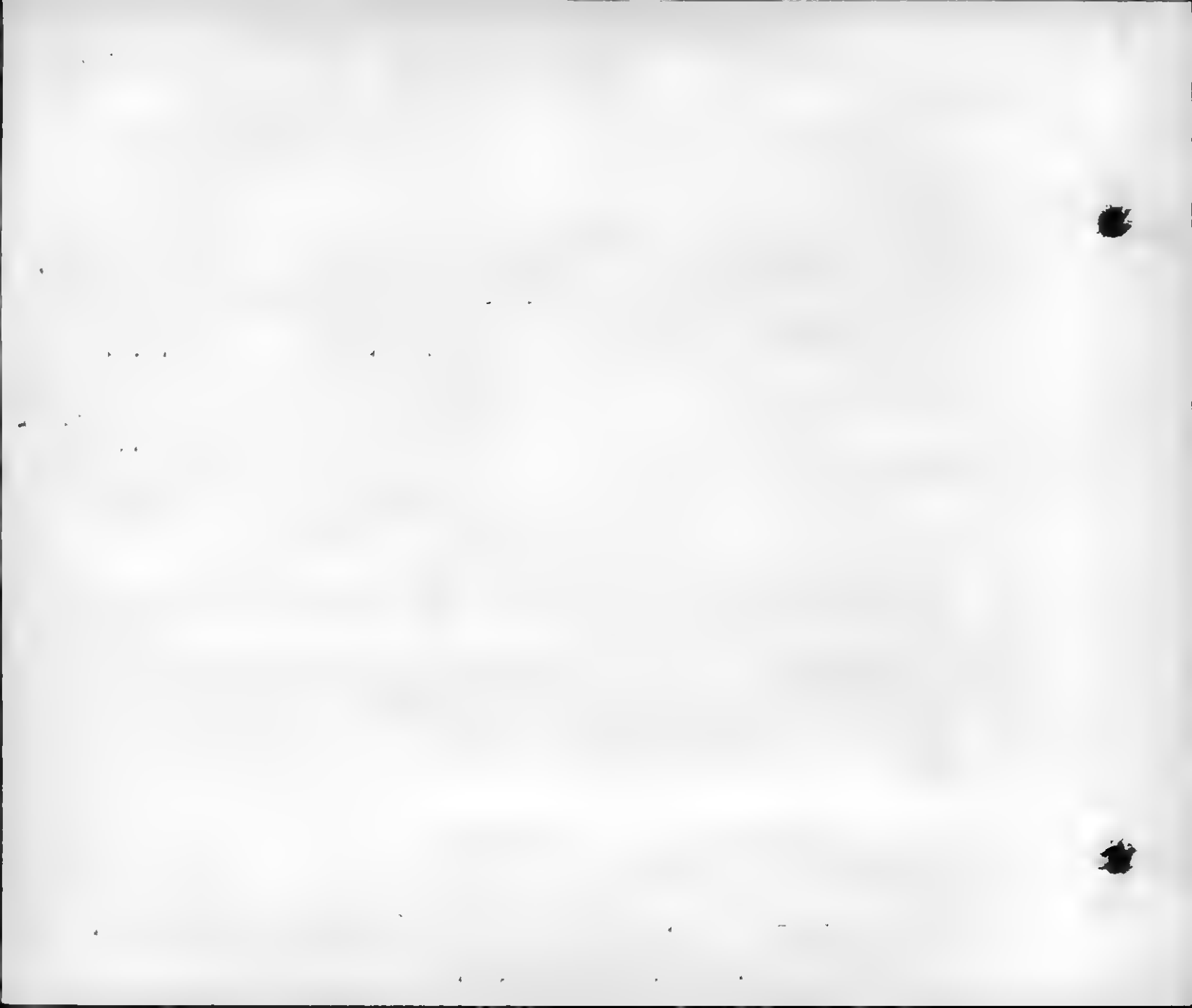
Reg. Dist. No. 06380

6360

Item 8 File 0230 0-4-1-1 58

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 51 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Young Last SELL		4. DATE OF DEATH Month JUNE Day 20 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 28, 1899
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Silk	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME L. JEFFERSON SELL (DECEASED)		14. MOTHER'S MAIDEN NAME RACHAEL WINTERS (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-6386	
17. INFORMANT PATIENTS CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malignant hypertension DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 19.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 19, 1958 to June 20, 1958 that I last saw the deceased alive on June 19, 1958 , and that death occurred at 1:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. W. Trevaskis, Sr. M.D. Cumberland, Maryland		DATE SIGNED 6/21/58	
PHYSICIAN'S NAME (Type) R.W. TREVASKIS, SR.		220 BALTIMORE AVE., CUMBERLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 23 58		24b. REGISTRAR'S SIGNATURE Alfred Smith	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6361 Item C-511-20-6-20-12 at
CERTIFICATE OF DEATH

06382

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/29/49	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Shoemaker		4. DATE OF DEATH Month June Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown Approx.
9. AGE (In years last birthday) 36 yrs		10. IF UNDER 1 YEAR: Months 36 Days 36 Hours 36 Min 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10b. KIND OF BUSINESS OR INDUSTRY W. VA. Lost City	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hezekiah N. Shoemaker		14. MOTHER'S MAIDEN NAME Mary Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT P.O. BOX 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 744.1 Coronary Thrombosis DUE TO (b) Chronic Myocarditis DUE TO (c) Congenital muscular dystrophy		INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Refractive			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 20, 1952 to June 13, 1958 that I last saw the deceased alive on June 13, 1958 , and that death occurred at 4:45 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 49 Green Street DATE SIGNED James E. McLean			
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED June 13, 1958	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Allegany County Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 16 1958		24b. REGISTRAR'S SIGNATURE James E. McLean	

None

No

elam

CERTIFICATE OF DEATH

Reg. Dist. No.

06383

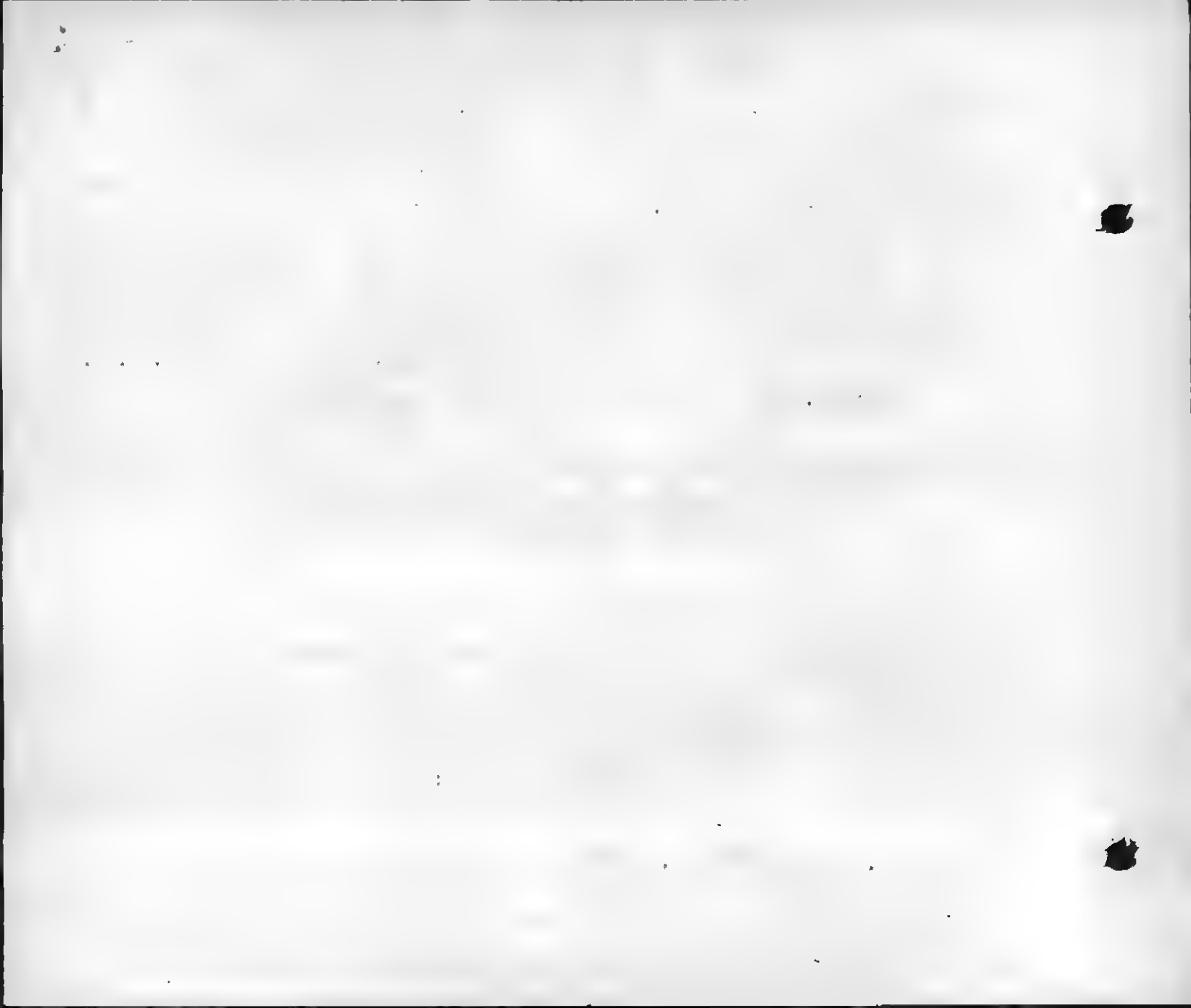
6362

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 131 S. Liberty Street	
3. NAME OF DECEASED (Type or print) First Carrie Middle Shuck Last Shuck		4. DATE OF DEATH Month June Day 1 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.	IF UNDER 24 HRS Months 88 Days 88 Hours 88 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Sewing	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Shuck		14. MOTHER'S MAIDEN NAME Mary Simpkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial degeneration 572x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) Chronic nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1951 , 19____, to 6/1/58 , 19____, that I last saw the deceased alive on 5/31/58 , 19____, and that death occurred at 3:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 6/2/58			
SIGNATURE Dr. James E. McLean			
PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3 1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JUN 4 '58		24b. REGISTRAR'S SIGNATURE W. J. Schuler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6364

CERTIFICATE OF DEATH

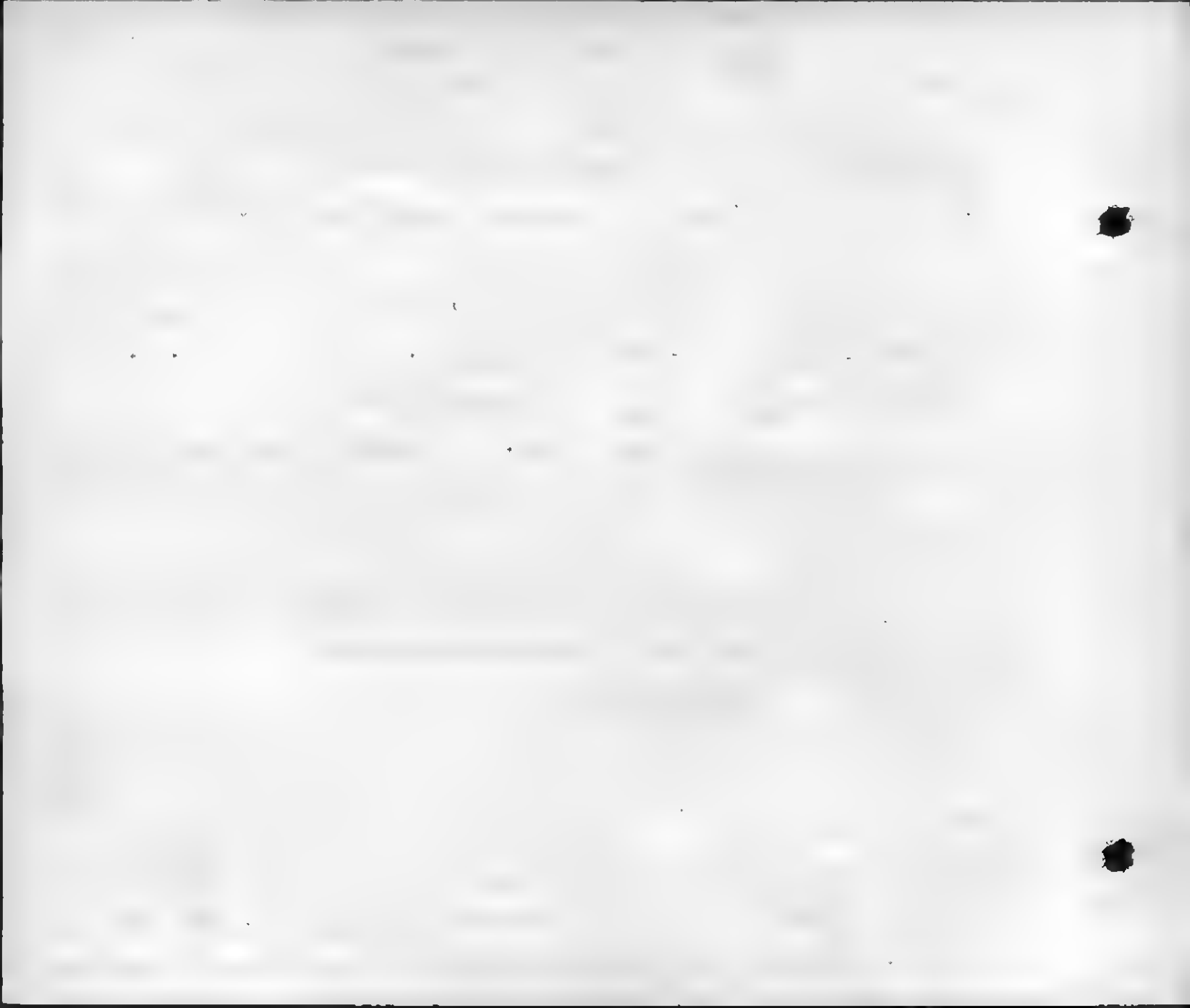
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution) Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 55 years				d. STREET ADDRESS 206 Columbia Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Columbia Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nola Middle Glenn Last Smith				4. DATE OF DEATH Month June Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5, 1864	
9. AGE (In years last birthday) 93 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME George Sellers		14. MOTHER'S MAIDEN NAME Rebecca Mower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ralph Ehrbar Address Cumberland, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infirmities of age							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 3-14-1948 to 6-4-1958 , that I last saw the deceased alive on 6-1-1958 , and that death occurred at 3a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE M. F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 6-4-58			
FUTURIST'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 6 '58	
				24b. REGISTRAR'S SIGNATURE W. A. Couch			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



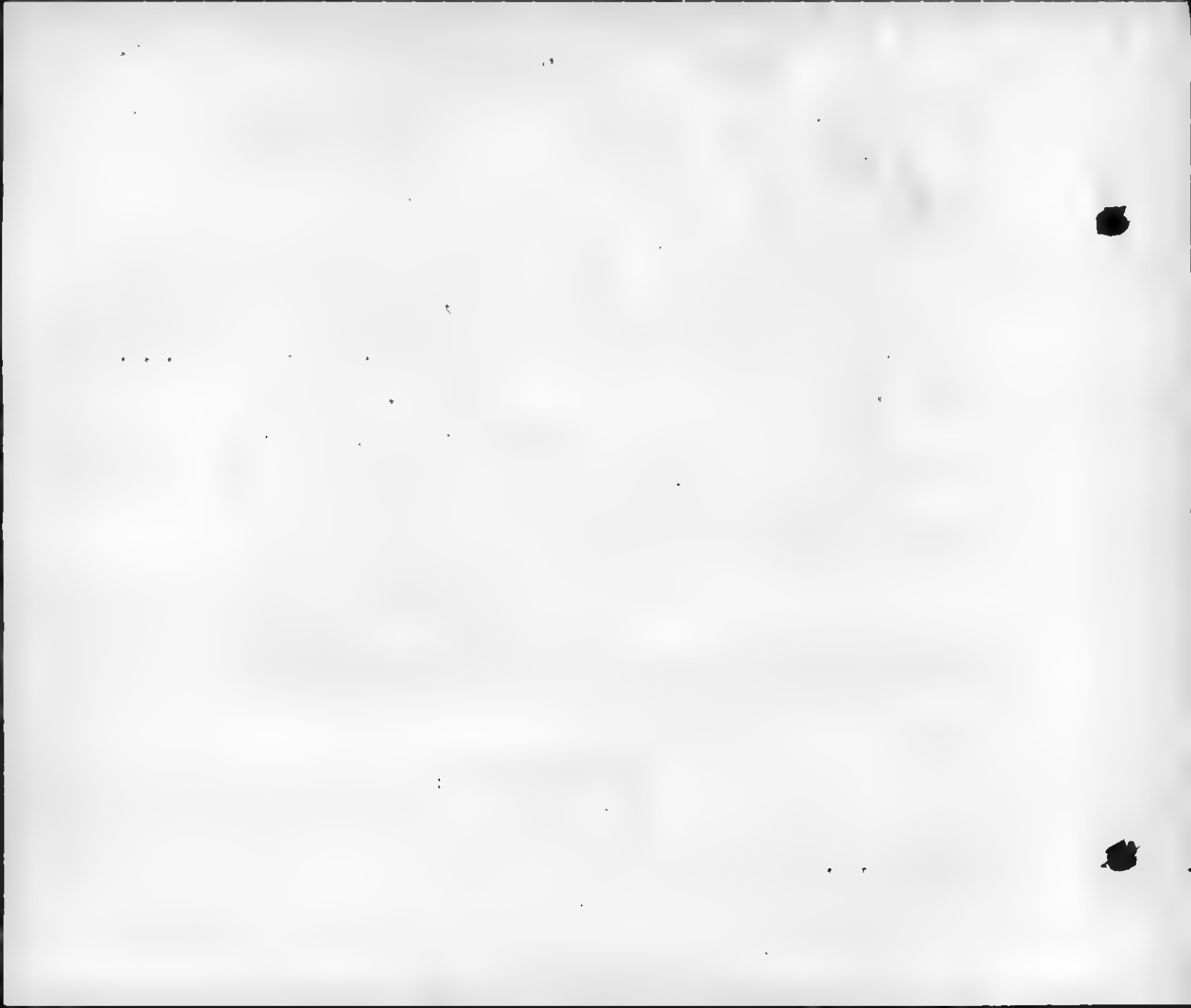
06386

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE	
ALLEGANY		MARYLAND	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d STREET ADDRESS POTOMAC PARK	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY STEIN		4. DATE OF DEATH Month Day Year JUNE 27 19 58	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 8, 1958	
9. AGE (In years lost birthday) yrs. 19		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE W. STEIN		14. MOTHER'S MAIDEN NAME HANNAH E. GOLLADAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis - Type not known</u> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 14 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1958, to June 27, 1958, that I last saw the deceased alive on June 27, 1958, and that death occurred at 4:16 AM, from the causes and on the date stated above			
ACTUAL SIGNATURE DR. O. HIMMELWRIGHT		ADDRESS (Street, city or town, state) 133 Va. Ave., Cumberland, Md.	
DATE SIGNED 6/27/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		6/28/58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Sunset. Manor Park		Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUN 27 1958		Per [Signature]	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2 57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06387

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If inst. tuition, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS DECEASED ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>ALBERT</u> Last <u>STOTT</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u>11</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired maintenance-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West. Md. R. R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Stott</u>		14. MOTHER'S MAIDEN NAME <u>Laura Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>220-03-7413</u>	
17. INFORMANT <u>Mrs. Nellie P. Stott, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hanging</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home (woods) Frostburg, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 24</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			



6366 CERTIFICATE OF DEATH

06388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		d. STREET ADDRESS 38 Elder St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Emma Virginia Twigg		First		Middle		Last		4. DATE OF DEATH 6 - 6 - 58		Month		Day		Year			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1862		9. AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Ownho me		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Robert F. Twigg		14. MOTHER'S MAIDEN NAME Christina Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Twigg Cumberland, Md. 38 Elder	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Stomach												18 mo.					
DUE TO (b) Arteriosclerotic Heart Disease												20 yr.					
DUE TO (c) Generalized arteriosclerosis																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Advanced age																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 14, 1956 to June 6, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.																	
ACTUAL SIGNATURE James P. Hallinan				ADDRESS (Street, city or town, state) M.D. 140 Bedford Street				DATE SIGNED 6-8-58									
PHYSICIAN'S NAME (Type) James P. Hallinan 140 Bedford St. Cumberland, Md.																	
22a. BURIAL, CREMAT OIN, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-10-58				22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem				22d. LOCATION (City, town, or county) Cumberland, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JUN 10 '58				24b. REGISTRAR'S SIGNATURE Overhoush					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06389

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cumberland,

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. # 1 Cumberland,

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D. O. A. Sacred Heart Hosp.

d. STREET ADDRESS

Box 732 Mt. Savage Rd.

IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

3. NAME OF
DECEASED
(Type or print)

First
LAURA

Middle
BELL

Last
TWIGG

4. DATE
OF DEATH

Month
June

Day
2,

Year
19 58

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

July 26, 1874

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Spring Gap, Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Amos Davis

14. MOTHER'S MAIDEN NAME

Sarah Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No,

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Mrs. Ruth E. Smith Rt. # 1 Box 732 Cumb. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Cardiac Failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Arteriosclerotic Cardiovascular disease

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
2 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.

19

20d. INJURY OCCURRED
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL
SIGNATURE

Benedict Skitarelic

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

Benedict Skitarelic, M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

June 2, 1958

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

6/4/58

22c. NAME OF CEMETERY OR CREMATORY

Mt. Pleasant Cem.

22d. LOCATION (City, town, or county)

Near Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George Cumberland, Md.

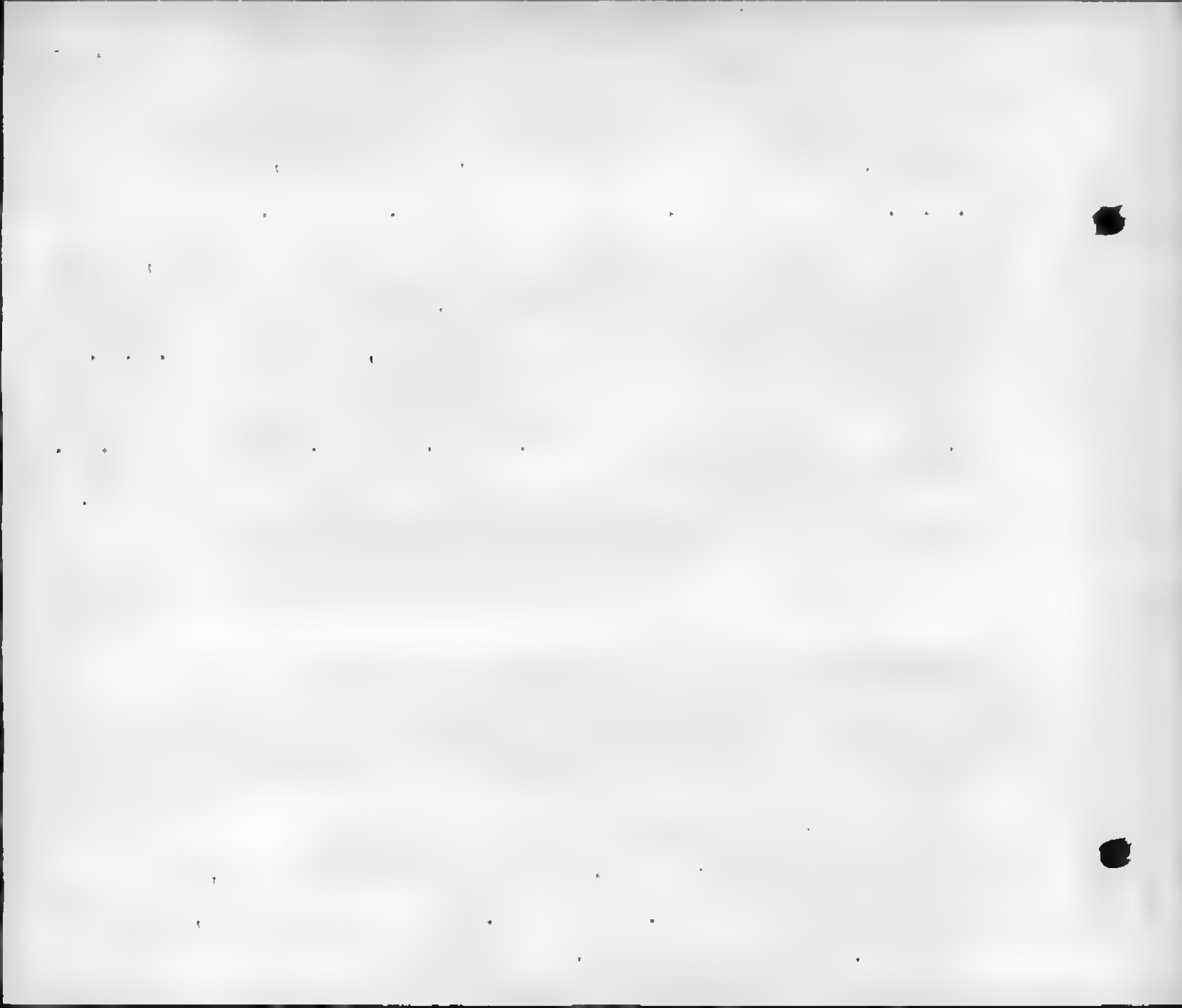
ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUN 4 58

Alfred Smith



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

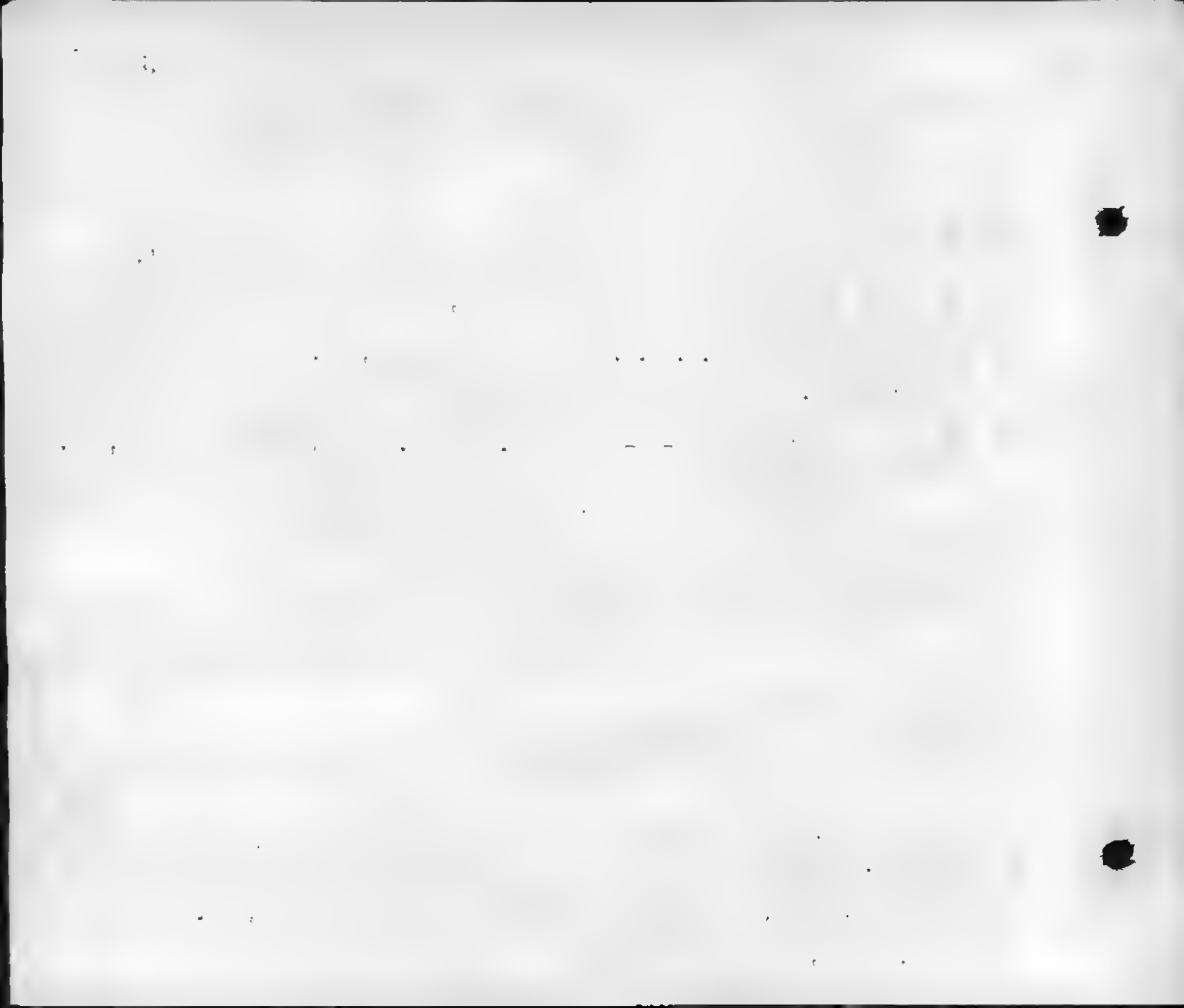
6401

Reg. Dist. No.

06390

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS	c. LENGTH OF STAY IN lb LIFETIME	c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) LITTLE ORLEANS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LITTLE ORLEANS		d. STREET ADDRESS LITTLE ORLEANS	
3. NAME OF DECEASED (Type or print) ROBERT RANDOLPH TWIGG		4. DATE OF DEATH Month JUNE Day 28 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 21, 1913
9. AGE (In years last birthday) 45 yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POSTMASTER		10b. KIND OF BUSINESS OR INDUSTRY U.S. P.O.	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WARREN L. TWIGG		14. MOTHER'S MAIDEN NAME MYRTLE RICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW 11		16. SOCIAL SECURITY NO. 217-18-4669	
17. INFORMANT MRS. LENA T. TWIGG, LITTLE ORLEANS, MD.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. Skitarelic		DATE SIGNED June 28, 1958	
EXAMINER'S NAME (Type) B. SKITARELIC		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 2, 1958	22c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	22d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAFFER, CUMBERLAND, MARYLAND		24a. REC'D BY REGISTRAR JUL 3 1958	
24b. REGISTRAR'S SIGNATURE John J. Hafer			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

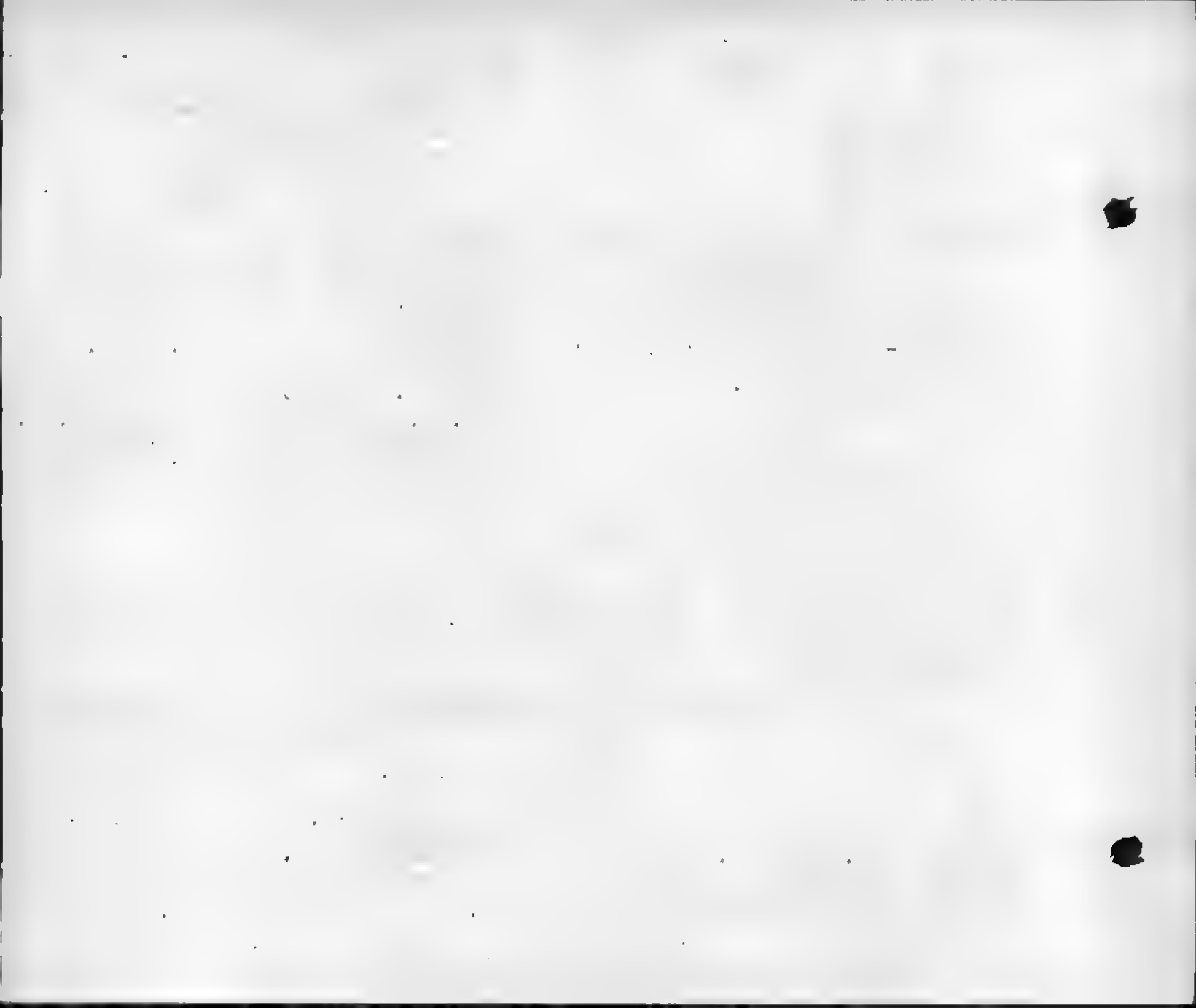
CERTIFICATE OF DEATH

Reg. Dist. No. **06391**

6368

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 6/16/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE OF A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emory Middle Lloyd Last White				4. DATE OF DEATH Month June Day 21 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Crystal Laundry Worker				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Algernom M. White				14. MOTHER'S MAIDEN NAME Sarah E. Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214 05 9026			
17. INFORMANT P. O. Box 599 Address Cumberland, Md.				18. MOTHER'S MAIDEN NAME Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration 597X DUE TO (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Nephritis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH ? ?							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/16/58 , 19 to 6/21/58 , 19, that I last saw the deceased alive on 6/20/58 , 19, and that death occurred at 7:05 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 6/21/58							
ACTUAL SIGNATURE James E. McLean				PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF June 24, 1958			
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cem.				22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				24a. REC'D BY REGISTRAR JUN 24 '58			
ADDRESS Cumberland, Md.				24b. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

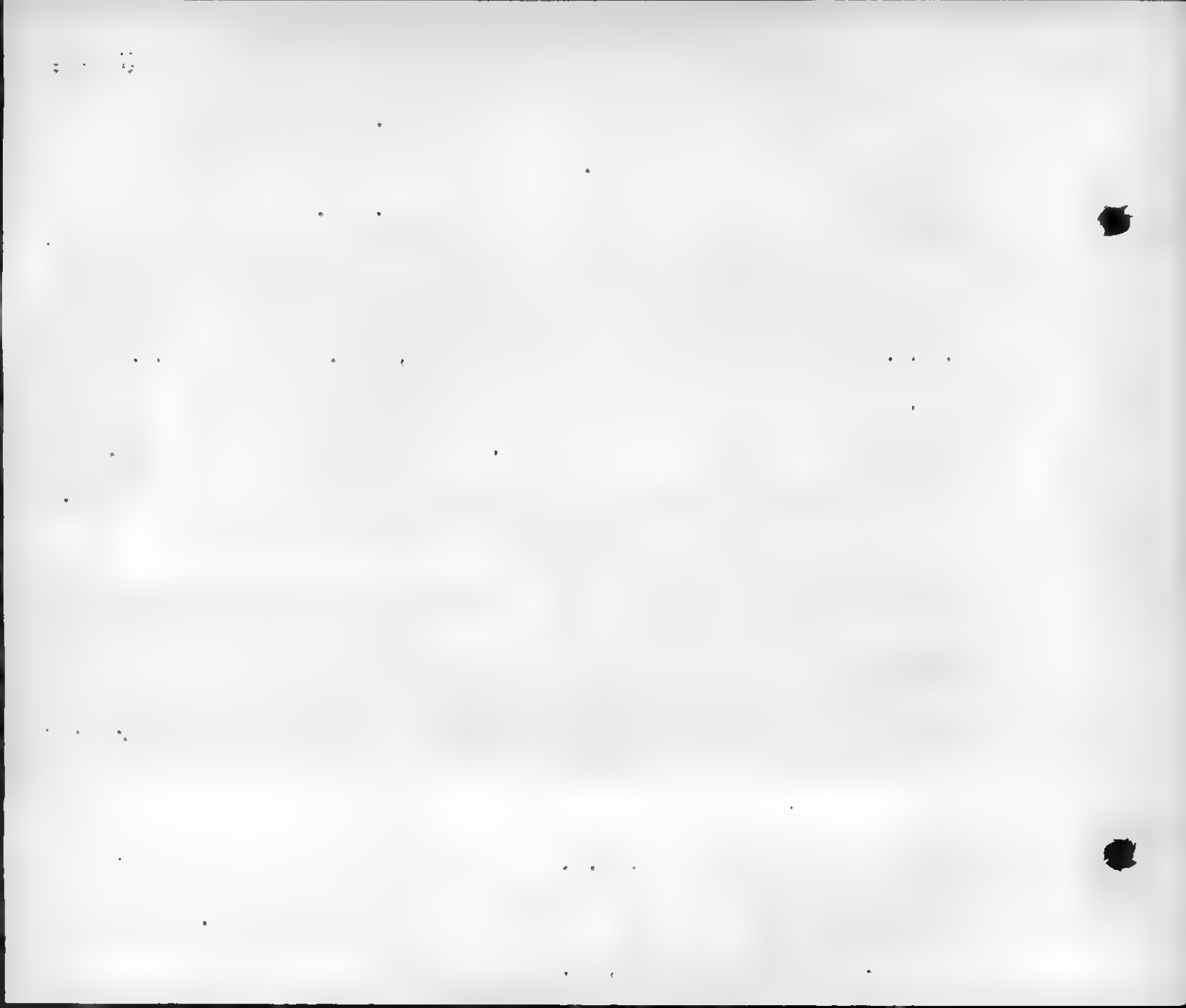
Reg. Dist. No. **06392**

6369

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tenn.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>46hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Second & C. Sts.</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas Lowell Wilds</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1936</u>
9. AGE (In years last birthday) <u>22</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pvt. U.S. Marines</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armed Forces</u>	
11. BIRTHPLACE (State or foreign country) <u>Newport, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jake M. Wilds</u>		14. MOTHER'S MAIDEN NAME <u>Oran McClure</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elizabeth Wilds</u>		Address <u>Newport, Tenn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Maceration of brain</u>			
DUE TO (b) <u>Skull Fracture</u>			
DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>10 June 14 58</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Near Romney, W. Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		DATE SIGNED <u>June 16, 1958</u>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		DEPUTY MEDICAL EXAMINER <u> </u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/17/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Newport Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6370

CERTIFICATE OF DEATH

Reg. Dist. No. 06393

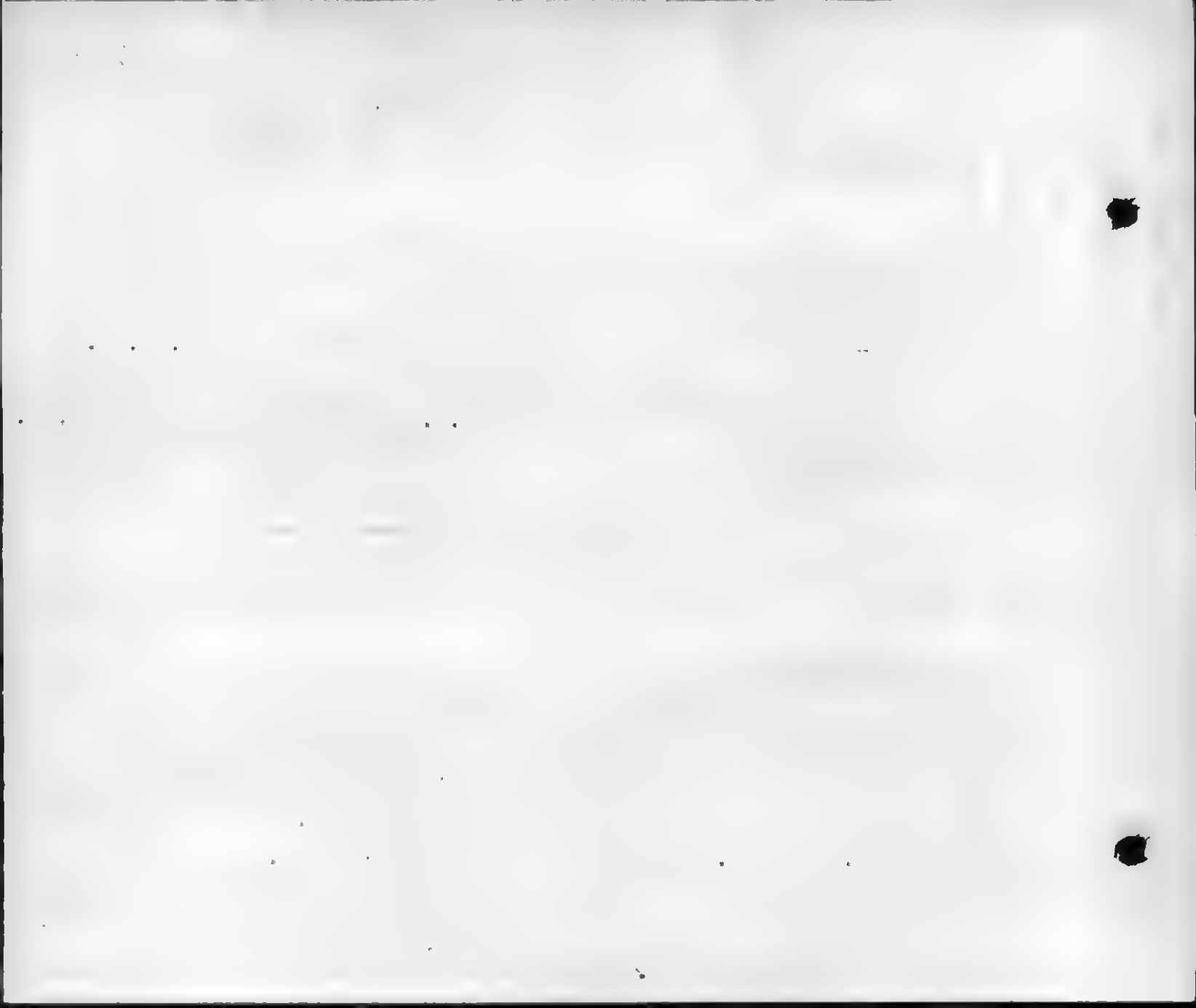
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2/15/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville	
3. NAME OF DECEASED (Type or print) First Middle Last Eliza Jeanette Winebrenner		4. DATE OF DEATH Month Day Year June 17, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Sherwood		14. MOTHER'S MAIDEN NAME Frances Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. Allegany County Infirmary Records	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		?
DUE TO (b) Cerebral arteriosclerosis		?
DUE TO (c) Chronic Nephritis		?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2/15/58 , 19 58 , to 5/17/58 , 19 58 , that I last saw the deceased alive on 5/17/58 , 19 58 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.		
ADDRESS (Street, city or town, state) 49 Greene St. M.D.		DATE SIGNED 6/17/58
ACTUAL SIGNATURE James E. McLean		
PHYSICIAN'S NAME (Type) Dr. James E. McLean		
Cumberland, Md.		

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 19, 1958	Porta Cemetery	Henderson, Pa. PA 1
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
Harvey D. Zeigler		JUN 20 1958	
ADDRESS Henderson, Pa.		25. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affix this certificate has been signed by the attending physician and completely filled out. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6371

CERTIFICATE OF DEATH

Reg. Dist. No.

06394

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 N. Centre St</u>				d. STREET ADDRESS <u>710 N. Centre St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Martha</u> Last <u>Youngblood</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 18, 1905</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>		IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Scottsdale Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James Zeller</u>				14. MOTHER'S MAIDEN NAME <u>Anna Fletcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>16801 Youngblood</u>			
17. INFORMANT <u>Helon Youngblood</u> Address <u>Cumb. Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertension</u> DUE TO <u>420.1</u> (c) <u>Arterio Sclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 30</u> , 19 <u>58</u> , to <u>June 3</u> , 19 <u>58</u> that I last saw the deceased alive on <u>June 3</u> , 19 <u>58</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L.B. Mathews</u>				ADDRESS (Street, city or town, state) <u>49 Green St</u>			
DATE SIGNED <u>6/4/58</u>							
PHYSICIAN'S NAME (Type) <u>L.B. Mathews M.D.</u> <u>Cumberland Md</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/5/58</u>			
22c. NAME OF CEMETERY OR CREMATOR <u>St. Patrick's Ch.</u>				22d. LOCATION (City, town, or county) (State) <u>Cumb. Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>							

CERTIFICATE OF DEATH

1971

Name of Deceased [Faint handwritten name]	
Date of Death [Faint handwritten date]	
Place of Death [Faint handwritten address]	
Cause of Death [Faint handwritten text]	
Manner of Death [Faint handwritten text]	
Age of Deceased [Faint handwritten text]	
Sex of Deceased [Faint handwritten text]	
Race of Deceased [Faint handwritten text]	
Marital Status [Faint handwritten text]	
Occupation [Faint handwritten text]	
Usual Residence [Faint handwritten text]	
Signature of Physician [Faint handwritten signature]	
Signature of Registrar [Faint handwritten signature]	

NOTED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06395**

6372

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 yr-4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS 309 Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Minnie Elizabeth Zehner			4. DATE OF DEATH Month Day Year June 12 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1884		9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Emanuel B. Erdman			14. MOTHER'S MAIDEN NAME Mary Dimmick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. John L Sammel Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Vascular Disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/58		22c. NAME OF CEMETERY OR CREMATORY New Rosemont Cemetery	
22d. LOCATION (City, town, or county) (State) Bloomsburg Penna		24a. REC'D BY REGISTRAR DATE JUN 16 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland					

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

WITNESSED my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1900.

CLERK OF COUNTY

NOTARY PUBLIC

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas.

WITNESSED my hand and the seal of the County of Dallas, State of Texas, this 1st day of January, 1900.

CLERK OF COUNTY

NOTARY PUBLIC